VETERANS AFFAIRS MEDICAL CENTER: QUALITY OF CARE

HEARING

BEFORE THE

HUMAN RESOURCES AND INTERGOVERNMENTAL RELATIONS SUBCOMMITTEE

OF THE

COMMITTEE ON GOVERNMENT OPERATIONS HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRD CONGRESS

SECOND SESSION

OCTOBER 8, 1994

Printed for the use of the Committee on Government Operations

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VETERANS AFFAIRS MEDICAL CENTER: QUALITY OF CARE

SATURDAY, OCTOBER 8, 1994

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HUMAN RESOURCES AND
INTERGOVERNMENTAL RELATIONS,
COMMITTEE ON GOVERNMENT OPERATIONS,
Albuquerque, NM.

The subcommittee met, pursuant to notice, at 1:30 p.m., in the Picuris Room, Albuquerque Convention Center, 401 Second Street, NW., Albuquerque, NM, Hon. Edolphus Towns (chairman of the subcommittee) presiding.

Present: Representatives Towns and Schiff.

Staff Present: Cherri L. Branson, associate counsel; Martine M. DiCroce, clerk; and Martha Morgan, minority professional staff member.

Mr. TOWNS. The Subcommittee on Human Resources and Intergovernmental Relations will come to order.

This hearing will examine the mission and qualities of veterans hospitals, clinics and nursing homes, and the role they play in caring for our veterans.

The Department of Veterans' Affairs offers extensive medical services. The VA health system is the largest managed care health system in the Nation. The system includes 171 medical centers, over 300 clinics and 132 nursing homes, which provide care for over 16,000 patients.

This VA medical system employs almost 250,000 professional, technical and support personnel and serves over a million patients and provides 24 million outpatient treatment visits annually. Finally, VA hospitals operate as teaching facilities. VA hospitals are affiliated with more than 100 American medical schools and over 100,000 of the Nation's health care personnel are educated and trained in the VA system each year.

The VA's primary mission is to provide medical, psychiatric and ancillary services to eligible military veterans. The VA provides a full spectrum of medical care for primary treatment to rehabilitation and long-term care. The VA system is funded entirely by Federal appropriations and is intended to cover those veterans to whom services are guaranteed by law.

However, because of funding, there are problems in access. These problems are worsened by an array of complex and confusing eligibility rules which lead to dissatisfaction among many patients.

In addition to questions over access to care by all veterans, concerns have arisen about the quality of care received by patients and

outpatients at that VA facilities. In part, allegations of VA's shortcomings have stemmed from its inability to deliver more services. Because of VA's dual mission of providing specialized care for veterans with service connected medical problems and functioning as a safety net for veterans with low incomes, health care at VA facilities is more expensive than at comparable facilities.

The vast majority of patients who routinely visit VA facilities are indigent or have disabilities incurred or aggravated during their military service. On average, VA's patient population is older, sicker and poorer than other health care providers.

In an attempt to address the concerns about the quality of care received at VA facilities, Congress requires the VA to have an extensive Quality Assurance Program. The goal of the program is to assure that each hospital can render quality care. These programs provide a framework for examining procedures used in providing care. All hospital directors are responsible for maintaining an effective Quality Assurance Program within the facility.

We are here today to assure that the congressional mandate for quality of care and access to services are carried out in New Mexico. I look forward to hearing from the witnesses today and I am certain that your experiences—on the battlefield and in the waiting rooms will provide us with a clear picture of the needs and concerns of the veterans and the necessity and value of the services provided by this facility.

At this time, I would like to pause and yield to Congressman Steven Schiff, a dedicated, committed, hard-working, highly respected, insightful and thoughtful——

Mr. SCHIFF. Is that an endorsement?

Mr. TOWNS. Member of the U.S. Congress. Steve.

Mr. SCHIFF. Thank you, Mr. Chairman. First of all, I want to begin by personally welcoming you and the staff members who are here from Washington once again to Albuquerque, NM. We appreciate your being here. We appreciate your interest in our community.

Second, I want to take a little longer moment, if I may, just to explain how this hearing came about.

We are a subcommittee of the Government Operations Committee of the House of Representatives. Chairman Towns, from the State of New York, is the Chairman of our subcommittee and I am the Ranking or senior Republican Member of the subcommittee.

The Government Operations Committee is the general oversight committee of Congress. In other words, the purpose of the Government Operations Committee is to take a second look at things. There is always a primary committee of responsibility, an Armed Services or Veterans' Committee or whatever it might be, and they have the jurisdiction over particular agencies and particular functions of Government.

The purpose of the Government Operations Committee is for Congress to have an investigatory vehicle to, an investigation means of oversight just to see how everything is running and to report back to the other Members of Congress, particularly other committees. And that is our primary function.

This subcommittee has jurisdiction over, among other things, the Veterans' Administration, Veterans' Affairs Department, and also

the basic health care programs operated by the Federal Government; namely, the Medicare and Medicaid Programs. And we have, back in Washington, held a number of hearings on the operation of various health care programs that are in existence now in the Federal Government.

Now, let me take another minute, if I may, to explain what brings this hearing about. One of the subjects that has come up frequently during the entire health care debate of the last 2 years has been the subject of health care for veterans, and this has been prompted by several factors. One factor is simply the increasing demand for health care in our veterans system, particularly as the veterans of World War II age and become in greater need of medical care.

Second, the veterans health care system came into debate as we debated the whole health care system. In other words, as we debated all of the proposals to change the health care system, many veterans organizations and individuals, understandably, would contact us as Members of Congress to talk about the veterans health care system and to ask about how a plan would affect the treatment they are now getting and how it would affect the health care and veterans hospitals.

So the subject of veterans health care has been really a very important issue to the Congress for the last 2 years. Now, coming to this subcommittee and this hearing, I want to say that occasionally the Congress goes out of Washington and goes into communities to see what is going on, rather than expecting all the time individuals to come to Washington to testify about what is on their mind, and in the discussion on health care, and particularly veterans health care, I proposed Albuquerque as this hearing site.

And the reason for that is that Albuquerque, of course, built and opened a new veterans hospital in the last few years. It has a unique—I will still call it an experiment. I am not sure we can say yet whether it has or has not worked well—I think it has and I hope it has—but it certainly has a unique program in sharing the facility completely with the Department of Defense, with the U.S. Air Force, in an attempt to share resources and, therefore, provide better health care both to veterans and to Air Force patients of the health care center.

Our health care center here has basically become a regional magnet for health care service to veterans, not only throughout New Mexico but in the region. Many veterans patients who need treatment more specialized than can be given to them where they live are brought to Albuquerque for treatment in our hospital. So I felt that our program would be one that would give a good view of how the veterans programs are running, because we are doing so much in the way of innovation here in this community.

I want to conclude by stressing that although I use the words, "investigatory nature of our responsibility," and that is true, that should not be interpreted as looking for bad news, necessarily. We are looking for what is going on and we are looking for the positive side also. If something is working well, we want to hear about that because we can share that with the Members of Congress with whom we work.

I want to stress that since Mike Harwell has become the Director of the VA Hospital here, his staff and my staff and the two of us individually work very closely together on many different items. And there are a couple of policy approaches we may not have agreed upon at times, but that is inconsequential to the idea of trying to work together from his responsibility and from mine to try to provide the best health care we can to the VA patients in this community.

So, Mike, let me welcome you here. Perhaps you could introduce who is with you here at the table.

Mr. HARWELL. Well, this is Sharon Barnes, and she is the Staff Assistant to the Director; fills many areas, one of which is congressional liaison between the medical center and your office and the other Congress and Senators' offices.

Don Noonan is my Director for the Quality Management Services, which includes responsibilities of the rural outreach clinics that we operate throughout the State. So he is very key to access to our programs, not only here in Albuquerque, but also at our satellite clinics throughout the State.

Mr. SCHIFF. Well, let me, as the representative of this area, let me welcome all three of you here and let me yield back to the chairman to begin the meeting.

Mr. TOWNS. Right. Thank you very much, and thank you for suggesting that we come to Albuquerque. First of all, being from New York City, just to see the beauty is enough to feel that it is a worthwhile visit. But above and beyond the beauty, I think the opportunity to learn is also very, very important.

I think that when we look at veterans and veterans' affairs I think it is important that we make certain our veterans have access. So thanks again, Congressman, for suggesting that we come to Albuquerque.

So, Mr. Harwell, we have your entire statement for the record and it will be included in the record. If you will just move forward by summarizing and then allow us some time to raise questions with you. You may proceed as you wish.

STATEMENT OF H. MICHAEL HARWELL, DIRECTOR, ALBUQUERQUE VETERANS' AFFAIRS MEDICAL CENTER, ACCOMPANIED BY SHARON BARNES, STAFF ASSISTANT TO THE DIRECTOR, AND DONALD NOONAN, DIRECTOR, QUALITY MANAGEMENT SERVICES

Mr. HARWELL. Mr. Chairman, Mr. Schiff, and guests, we are very pleased to have this opportunity to discuss the programs and the services of the Albuquerque VA Medical Center. We sincerely appreciate your interest and support of our hospital.

As you know, Albuquerque VA Medical Center offers a wide array of programs and services. What you may not know, however, is that the Albuquerque VA med center is one of the most comprehensive and progressive facilities in the VA system.

Last year, we provided more than 9,800 episodes of inpatient services and had in excess of 250,000 outpatient visits. We are regularly making customer focused improvements in our delivery system and will continue to consider the needs of our veteran population as our highest priority.

The past year we have established a women's clinic in a setting sensitive to their needs. We recently implemented customer service standards to communicate our commitment to excellence to our patients. I have provided a more extensive summary of our hospital programs in my written testimony, as you have stated, and I would be very pleased to try to answer any questions you may have.

[The prepared statement of Mr. Harwell follows:]

Good afternoon. I am pleased to be here today, along with some of my staff, to provide you with information on the Albuquerque VA Medical Center for your reviews of patient care in VA hospitals. We are appreciative of your interest in VA health care and in the Albuquerque VA Medical Center.

I am happy to report that the Albuquerque VA Medical Center is experiencing a controlled growth in both patient workload and funding to support those activities. In addition, we continue to enjoy a strong affiliation with our DoD sharing partner, Kirtland Air Force Base Hospital. As a result of this partnership, we are about to become one of the very first VA Medical Centers to sponsor an accredited medical residency training program in emergency medicine.

We are particularly pleased that this Medical Center has begun to see substantial benefit from the national budgetary distribution methodology based on patient capitation. As a result, we have been able to proceed "ahead of the curve" with a number of innovative and exciting patient care programs, such as enhanced ambulatory surgery programs, endoscopic surgery, and we are particularly proud of our transition to a patient-responsive primary care model. In effect, we have established "group practices" that will identify an individual provider for each patient to fully manage his or her care. We have already enrolled nearly half of our patient population in a group, with plans to complete this realignment of services within the next year. We are striving to complete this transition to the primary care model of managed care for two principal reasons. First, we believe it represents the most effective manner of delivering patient care, and second, the benefits and convenience of easier and more timely access to care for our patients are part of our comprehensive customer service program.

We have managed our patient care demands, along with the transition to primary care, ambulatory surgery and other programs, through a combination of staff realignments, program efficiencies and contract services.

While we recognize that our priority is the delivery of patient care services, we also acknowledge the need to maintain the integrity of the physical plant in order to provide a safe, clean and aesthetically pleasing environment in which to deliver this care. Adequate resources must be devoted to the variety of additional space, renovation and remodeling projects to house new programs and equipment to enhance the quality and scope of programs we provide. For example, we will begin construction at the hospital in January for a $2.7 million outpatient addition that will nearly double our existing ambulatory care services area.

As a result of this combination of programs and physical plant, the Albuquerque VA Medical Center is staffed and equipped to provide services on a par with any other hospital in the community. The most widely acknowledged and respected indicator of quality care nationwide is the Joint Commission on Accreditation of Healthcare Organizations survey score. I am proud to report that the Albuquerque VA Medical Center is among the highest,

with VA Medical Centers nationwide scoring an average of 10 points higher, on a scale of 100, than their community counterparts.

I would like to spend a few moments discussing a couple of our patient programs of which we are particularly proud. Our women veterans' health program is state of the art. It is a comprehensive approach to recognizing the unique needs of this veteran population, encompassing both primary and specialty care, supported by a dedicated clinic, mammography, bone densitometry and specialized mental health services. To date, we have 574 women veterans enrolled, one of the largest enrollments of women veterans of any VA Medical Center in the system.

Our occupational and physical rehabilitation programs offer a full range of services, closely integrated with all of our patient care programs, including spinal cord injury, psychogeriatrics, cardiac rehabilitation, prosthetics and orthopaedics. Our spinal cord injury patient courtyard design has been nationally recognized. We are now installing the Automated Fabrication of Mobility Aids (AFMA) System for the design of artificial limbs, truly a state-of-the-art fabrication system pioneered at the Seattle VA Medical Center.

Our substance abuse programs are in a process of transition as we strive to provide treatment that is comprehensive and appropriate, yet more in concert with veterans needs for outpatient treatment rather than institutionalized care. Our goal is to provide a program that improves the outcome of patient care efforts by reducing recidivism rates and maximizing the patient's own support structure of home and family relationships. One piece of this treatment spectrum, the Gallup Outreach Program, has been enhanced in two ways, now incorporating a VA-run and VA-sponsored halfway house as well as expanded primary care medical services to supplement its original substance abuse referral and follow-up mission.

While I have already spoken to the changes taking place in our outpatient services at the main facility in Albuquerque, I would like to tell you about outreach efforts. Clinics in Farmington, Artesia, Silver City and Raton are functioning as strong primary care programs for veterans living in these communities. Gallup recently expanded its medical treatment capabilities, and we have just activated an agreement with the Health Centers of Northern New Mexico, a not-for-profit, certified rural health clinic organization, comprised of primary care clinics located in 10 communities throughout northern New Mexico. Our first shared activity is now in operation in Las Vegas, NM, and it is our hope that several more can be actuated by the end of fiscal year 1995 if this contractual agreement proves to be an effective health care delivery approach.

It was indicated to me that the Subcommittee is particularly interested in the potential consolidation of functions between the VA Outpatient Clinic in El Paso and the Medical Center in Albuquerque. It is premature for me speak to any conclusions in this matter as no final decision has been announced by the VA Secretary regarding the level and nature any consolidation may have. However, the Secretary has made it clear he will approve no plans that would either close facilities or reduce the quality or quantity of services to veterans.

The Veterans Health Administration called upon the directors of these medical facilities to develop preliminary plans to integrate the two facilities under one management structure. The plan's objective is to develop more cost-effective services by eliminating duplications, reconfiguring services to better meet veterans needs, and redesigning functional relationships. The proposals developed were based on the premise that quality and quantity of services to veterans served by the El Paso and Albuquerque facilities, or any other VA facility, will not be diminished.

This Medical Center has experienced one of the highest ratios of patients served-to-veteran population in the country. Our "market share" is more than twice the national average, and is growing annually. Overall statistics that might be interesting to note include the fact we currently have 32,000 veterans in our active caseload. Of this total, approximately.13 percent are from Texas and other neighboring states, attesting to the nature of our tertiary care referral services. In FY '94, we provided 9,800 episodes of inpatient care and performed more than 250,000 outpatient visits. Thirteen percent of these, more than 31,000 outpatient visits, were conducted in our community clinics. The largest of these continues to be in Artesia, which last year provided more than 10,000 outpatient visits.

Mr. Chairman, I appreciate this opportunity to discuss health care programs at the Albuquerque VA Medical Center and I will be pleased to answer any questions you may have.

Mr. TOWNS. Thank you very, very much. Let me begin by saying, in reading your testimony, you indicated that block scheduling as something that you use. How does block scheduling work?

Mr. HARWELL. Well, block scheduling is when you have, say, 8 providers with, say, 16 examining rooms, and you would have 8 to 10 patients scheduled at the same time because they all go into a room with a provider. Now, block scheduling can be a bad thing if you do not have multiple providers to see those people.

Mr. TOWNS. What is the waiting time? Two questions, No. 1, what is the waiting time, and then after I get that, the second followup to that, how can you reduce it?

Mr. HARWELL. There are different waiting times according to the different ways you access the system. There are three basic ways that you can access our system. One is you come into the emergency room in an emergency. There the waiting time is very little, if any, according to your medical need.

Another way you access our system is to have a scheduled appointment to one of our clinics. That means you have an appointment time. We try to see you, our goal is to see you within 30 minutes of our appointed time.

The third way is a little more troublesome, and that is when you walk in, not an emergency case, but do not have an appointment. That is seen in our urgent care area. That waiting time strictly is based upon your need, your medical need compared to the other patients' medical needs that have presented themselves. So that is the one that is very unpredictable.

We are unsatisfied with that urgent care system and are having staff, medical staff, to come up with a plan to improve that system by following all the emergency room work and the urgent care work together so we can have more providers for people who walk in without appointments.

Mr. TOWNS. You know, in some parts of the country, I don't know about here, there is a big problem with homeless veterans. Do you have a problem here with homeless vets?

Mr. HARWELL. Well, I am sure—we have homeless vets, that is very true.

Mr. TOWNS. But if you are treating someone in the hospital that is homeless, what do you do in terms of when it comes time to discharge them? What is the process?

Mr. HARWELL. We have several placement programs, and some of the service organizations offer some placement potential for homeless veterans. We have a transition ward where we can hold a patient until we can get appropriate placement. So we work all the time with our social services to accomplish that, with the community assets and with service organizations.

Mr. TOWNS. Now, I understand that you have a transportation system, a transportation service for the veterans, which is largely operated by volunteers. Is there a way this service could be a part of the hospital routine? Because volunteers are volunteers.

Mr. HARWELL. Well, the transportation program that we have is operated by the DAV. They donate vans, they run the program, they run the volunteers and they provide the transportation. And, by the way, they do an excellent job for us in that area.

Mr. TOWNS. So it is no problem in terms of transportation. It is always available basically for the veterans; is that what you are saying?

Mr. HARWELL. It is available for veterans who need it, and they serve our outlying areas, too. We have clinics far distances from here, in Farmington, Artesia, Raton, and this DVA transportation system does an excellent job of coordinating that transportation for veterans. We really would have big problems if we did not have that.

Mr. TOWNS. I see my time has expired. Let me ask one more question before I yield to my colleague.

We have more female veterans. I think the number is increasing. As we watch and see more women going into the military, can you tell me about the special services to ensure that the needs of women veterans are being met?

Mr. HARWELL. We are fortunate here in Albuquerque, because, as Congressman Schiff mentioned, we have a joint venture with DOD which has a high density of female patients, both active duty and dependents. So our facility is used to serving a larger percentage of women than most VA's.

To give you an example of how that works, where some VA's have to contract for mammography services, for screening, we have two mammography machines that the Air Force operates for us and does that kind of care.

We recently, just this year, opened a women's veterans clinic, which has primary care providers who are sensitive to the needs of women and who take care of those women veterans on a recurring basis. In other words, they see the same provider every time they come in and they can get all their services, both primary care, gynecological care and specialty care, in that one setting.

So we feel that we have made a big stride forward in that area.

Mr. TOWNS. Thank you very much. At this time, I yield to Congressman Schiff for any questions he may have.

Mr. SCHIFF. I just have a few things I want to go into with you, Mike. But I want to stress again that I proposed Albuquerque for the site of this hearing when the chairman expressed an interest in studying veterans health care more closely, because from everything I know, we have been a leader here in New Mexico in a number of programs.

I believe, for example, that it wasn't that long ago we opened a spinal injury unit, for example. Could you tell us a little about that, please?

Mr. HARWELL. That is right. We opened that about 3½ years ago. It was well under construction when I came from Amarillo in 1990 where I was the director before, but I was in this medical district, which means I met in Albuquerque and was familiar with that facility. So we opened that. It is a very nice facility. It is a single story. It has a beautiful aftereffect. It has a very nice enclosed family patio. It has an indoor swimming pool for therapy. We are very proud of that facility.

Mr. SCHIFF. Are there many such facilities in the VA system?

Mr. HARWELL. I think there are 60-some-odd—do not hold me to that—60-some-odd spinal cord injury centers throughout the VA. We are in the only one in the Southwest area.

Mr. SCHIFF. That is what I was going to ask. We are the only one in this neighborhood, so to speak.

Mr. HARWELL. That is correct.

Mr. SCHIFF. I think it is important to note that your hospital was selected for that particular program.

Let me ask about consolidation. The Veterans' Hospital has been consolidated with the Air Force hospital for a relatively long time now, a number of years. I have heard mostly good reports from that consolidation. Both Veterans' staff and Air Force staff told me that by combining resources you have been able to provide programs and equipment and services that one or the other program might not be able to provide on their own funding.

I have heard some complaint from some individuals—some individuals on the veterans side believe their service has slowed down because of service to Air Force personnel. I have talked to Air Force personnel who think their service has slowed down because of the veterans. I have not heard much in the way of complaint, I must say.

I would like to ask you—and you have been our director for several years—what is your view of the consolidation with the Air Force? Do you think it has been a good decision, worthwhile on the whole; do you see it as a positive or do you have significant reservations about it?

Mr. HARWELL. I will answer this way, Mr. Schiff. When it started in 1989, it started as a collocation. In other words, they were juxtaposed to us with everything duplicated. They had their own emergency room, their own laboratory, their own x-ray, their own wards, their own physicians, and they just rented space from us and built some new space.

Over the years, we have become consolidated and integrated. We now have a single emergency room. We have a single imaging service. We have a single pathology service. We are integrating logistics as we speak, and we are wanting to integrate surgery this year. So we believe that it has been very beneficial or we would not have made moves to further integrate these services.

It is particularly interesting, that's correct, yes. They bring a lot of things to us that we would not normally have, such as primary care physicians, such as primary care providers, because they have always had a large primary care system. We bring things to them they would not have unless they went to a much larger hospital, like San Antonio.

So I think it is very beneficial and very cost effective, and we believe that we provide better service being integrated to this.

Mr. SCHIFF. So you are very positive about that.

Mr. HARWELL. I am very positive about it.

Mr. SCHIFF. Now, there has been discussion, although I don't think it has gone past the discussion stage, of consolidating Veterans' Hospitals in the VA system in the area in some way. I have not seen a specific plan. I do not know that one exists. I think it has just been a discussion.

Do you have enough information to have any prediction about whether that will happen and what it may mean if it does happen or is it still just so much in the formative stage?

Mr. HARWELL. I think that is true, Mr. Schiff. I think it is very much in the formative study phase. There is not one very close to us, as you can imagine, because we are the single facility with our satellite clinics in the State. I think the ones that have been at least in the discussion stage are in other places where they are closely together and can share logistics and these kinds of things.

Mr. SCHIFF. You mentioned the satellite clinics. Before I go on to that, I would be interested in being kept apprised of moves toward consolidation so I know what is happening so I can be accountable to the veterans I meet in the community.

You mentioned satellite facilities. One of the situations that exist in a State, with some urban centers, but a lot of rural areas, is how to provide access to those people, whether it is veterans or anything else, but here we are talking about the veterans system, to those people eligible for a program, but who do not live, in this particular case, in or near the Albuquerque area.

Could you tell us a bit about the satellite clinics that have been set up and where they are and what do they do?

Mr. HARWELL. We have four that are up and operating full-blown right now. One, our largest, is in Artesia; our second largest is in Farmington—I am speaking of large by number of social security numbers that they have enrolled—our third largest is in Silver City; and our smallest is in Raton.

We, at the present time, also have an alcohol and substance abuse outreach center in Gallup. Very soon, this year, we are going to add a medical component there and make that clinic an all-service clinic and not just a substance abuse.

We have some other ideas about increasing our access and have done so in the Las Vegas area with what we call an alternative based clinic, which means we do not have VA staff there, but contract on a per diem basis with the health care clinics in that area to provide service to eligible veterans. We have one of those and we are looking at maybe establishing several more, maybe two or three more.

We are also looking at other sites that we may increase access in the rural areas by opening community-based clinics where the enrollment would justify doing that.

Mr. SCHIFF. One last item. The reason many people come to my office or the other representatives or Senators is often some difficulty in dealing with a bureaucracy, something happens like their records have gone the wrong way or something of that nature.

I have always had the feeling that for many agencies the people come to us. We are happy to serve them, but I have always had the impression they have come to us before they have asked within the organization for assistance that might just solve the problem on the scene.

Does the Veterans' Hospital have a patient representative program, where, let us suppose somebody feels, on items ranging from their records are not in the Albuquerque facility to they feel that they should have a different medication, something on the professional level; do you have a program where they can bring this to someone's attention so that the administration is aware of it?

Mr. HARWELL. We have three different programs that would serve somewhat all of those situations you have enumerated. First,

we do have an ombudsman program. We have two hospitals ombudsman; one primary on the inpatient side and one primarily on the outpatient side, but not exclusively. Those are full-time funded positions and are there to do that function.

Mr. Noonan here also runs the managed care office. This consists of four nurses, which are involved with continuity of the patient's care, from transfers from the facilities in west Texas and transfer back, bringing them in from the satellite clinics to the specialty clinics in Albuquerque, and so they try to assist in managing that care. Not only the care, but the transportation, the records transfer and those myriad of things that you need to do to bring someone from a distance.

And then our third program, which I call it my fail-safe program, is that we have the Call-a-Nurse Program, where we have an 800 number and any patient who has a question about their medication, that has a question about their next clinic appointment, has a question about their compensation and pension exam, anything, can call this number, a nurse will call that patient's record up on the computer and discuss with that patient or his family the situation that he has a question about.

So there are three things there they can use.

Mr. SCHIFF. Just one last question. Do you work to publicize these programs so patients know they are available if they run into a difficulty with the system?

Mr. HARWELL. Yes, we have a newsletter we publish them in. Don here has even gone so far as to have the little magnets you stick on your refrigerator.

Mr. SCHIFF. Phone numbers.

Mr. HARWELL. That has the phone numbers, the 800 number. So we do that as much as we can. We probably are not as good on our marketing as we should be, but we are learning. We are learning there.

Mr. SCHIFF. I want to thank you all for the testimony and yield back, Mr. Chairman.

Mr. TOWNS. Thank you very much.

Let me just ask a couple of quick questions. The Managed Care Program, how long have you been involved in managed care.

Mr. HARWELL. We started that office about 18 months ago. And the reason we started it was not for what you hear about managed care such as an HMO. We started because this is a referral center and a very great many of our patients come from other centers, referred to us. And we had patients showing up from, say, Amarillo, which is 275 miles away, or Big Spring, which is 300 miles away, or El Paso that is 278 and they would show up on a referral and they would not have their x rays. They would not have their medical records. They would not have their lab tests, and so we did it to help manage the patients that were coming from afar to be sure that we did not waste their time or have to duplicate things.

But as it has grown, I think we are doing that for our own patients now, because continuity is very important to us, particularly if you are in a referral center and you need to be sure that once that patient has seen the cardiologist that his primary care provider referred him to that that patient and his records and his consultation gets back to that primary care provider.

So we started it for our external referrals, but it has been so successful we are going to pursue that for all patients.

Mr. TOWNS. Let me thank you again for your testimony and to say to you that I think you have been very, very helpful. You know, the problem that we have, sometimes, in this country is that when you start looking at things and trying to move things around you find that this country is so different. The needs in one area are so different from the needs in another area. I think that is the one thing that got me a little nervous when we started talking about health care reform.

We have to be sensitive to what the needs are. In hearing from you today, of course, we will make a record of this so that other Members of Congress will read what you have said here. I think that helps us in terms of being in a good position next year. I am certain if we revisit health care reform again, I think the next time we will have learned something. And maybe we won't grab it all at one time, but maybe do some things on an incremental basis. And I think the information you have given us here will be very helpful in that regard.

You are going to receive a phone call from me because I want to know more about those volunteers. I come from New York and people do not like to volunteer, and when they volunteer, it does not work too well. So I want to find out how you get that going so you can expect a phone call from me.

I will not do it here today, but I am going to call. I want some paper and information from you on your program. I think when we look at where we are today, we need a lot of things to make programs work. We need volunteers and we need to find out how we can sort of get them involved in terms of the activities, so here, again, thank you very, very much for your testimony and we look forward to talking with you further. So thank you very much, Miss Barnes, and thank you, Mr. Noonan, and thank you, Mr. Harwell.

Mr. HARWELL. Thank you.

Mr. NOONAN. Thank you, sir.

Mr. TOWNS. Michael D'Arco, who is the director of the New Mexico Veterans Service Commission, Ben Montoya, who is the North Carolina Director of the Southwest Region of the American Ex-Prisoners of War, please come forward. And Mary Chavez Cox, chairperson of the Women Veterans New Mexico State Council of the Vietnam Veterans of America, please come forward.

Welcome. We have your statements, which will be included in the record. If you could just summarize within 5 minutes I would certainly appreciate it.

But let me just say that when we start out, the light is on green and when your 5 minutes is up the light turns red. Just in case you lose track of the time, we have the timer to help you out. So at this time let me yield to my colleague, Congressman Schiff.

Mr. SCHIFF. Well, let me turn to the witnesses for testimony, and let me just remind you, as the Chairman said, that your whole written testimony, if you have given us written testimony, will be made a part of the record. So you are welcome to summarize and then we can have some time for some exchange here.

I would propose to start with Mr. Mike D'Arco. He has been living and breathing veterans' affairs as our State director for as many years I have known him, if that is OK.

Mr. TOWNS. Sure. Be delighted.

Mr. D'Arco.

STATEMENTS OF MICHAEL C. D'ARCO, DIRECTOR, NEW MEXICO VETERANS SERVICE COMMISSION; BEN MONTOYA, NATIONAL DIRECTOR, SOUTHWEST REGION, AMERICAN EX-PRISONERS OF WAR; AND MARY CHAVEZ COX, CHAIRPERSON, WOMEN VETERANS, NEW MEXICO STATE COUNCIL, VIETNAM VETERANS OF AMERICA

Mr. D'ARCO. Mr. Chairman and members of the committee, I certainly thank you for the opportunity to appear before you today, as I am sure many of the veterans do, because it is very difficult, as you stated earlier on in the afternoon, for everybody to travel to Washington, DC, especially given the limited amount of resources that we have here.

I see my reputation precedes me, as the Congressman has a red light and a green light here. I usually talk too long. And I don't want you to hold it against me, since I am formerly from the Bronx, and came out here for a day, like you did, and never went back, but you have to go back.

Mr. TOWNS. After seeing the beauty, I understand that.

Mr. SCHIFF. And I do not need another person running for Congress around here, so please go back.

Mr. D'ARCO. Mr. Chairman, as I stated in my testimony, I have been director of Veterans' Affairs for the past 7½ years, nearly 8 years now, and our commission is a State-funded organization. There are no Federal funds whatsoever in our budget. It is all general fund money. We are supported by the taxpayers and we have some 16 offices statewide throughout the State of New Mexico.

Some of the issues that are mentioned in my testimony you have touched on. Although I have not specifically outlined these areas, one in particular, the transportation program, you mentioned earlier, and the volunteer program, and I would like to mention them and then yield to some questions at the end.

The VA's medical center volunteer program for transporting veterans to the clinics and the VA medical center in Albuquerque is subsidized by the taxpayers in New Mexico. We provide those volunteers. There is an incentive. Some use their privately owned vehicles for reaching or taking other veterans to health care, and we provide $75,000 through the State of New Mexico to the disabled American veterans to reimburse their drivers for mileage.

So we are transporting and the State is subsidizing that effort to get our veterans to the medical center and to the clinics for care to the tune of $75,000 per year. We do have a budget request in my budget this year, to our legislature, to increase that to $100,000, which will allow us to meet some ADA standards so we can provide transportation to wheelchair-bound and seriously handicapped veterans as well.

I would mention on the rural clinics, something that is not in the testimony, that although we provide transportation to the rural clinics and the hospital as well, I think a little bit needs to be done

on the side of our Native American veterans. There is not enough contact being made not only by the medical center, but at the regional office, as well, with Native Americans so that they know what is available to them and so that they can access care.

For the most part, we in the State think that the clinics work well. Some work better than others. With some it is a matter of funding, as I understand, which we would certainly hope you, Mr. Chairman, and the members of the committee can help with funding for additional staff in these clinics. We know that there is just so much money to go around, but without adequate staff in the clinics and adequate staff in the hospital, that causes delays, as you will hear in some of the other testimony.

I mentioned also that I serve and have the honor to serve on Secretary Brown's committee, the Veterans Advisory Committee on Rehabilitation, and several weeks ago a majority of the advisory committee met in Albuquerque and we spent most of our time in the rehab medical center, and also spent some time, for a short briefing and a tour of the spinal cord center. The presentations that were made to the committee left the committee with the opinion that the medical center care that was provided for rehab medicine is good quality care.

As I mentioned in the testimony, again, many of the veterans are being released back to home and family and some back to employment. That is far more, from what I have seen in the charts that were provided to me, than in most medical centers in the country. Many of the medical centers in the country after rehab and after surgery or stroke or whatever it may be, individual veterans are returned in many cases maybe to nursing home or to some other hospital-type facility for medical care. Here they seem to be doing a little better job in their rehab medicine and they do have some dedicated staff people.

You mentioned earlier, Congressman Schiff, the Air Force relationship with the VA medical center. And you know I was not exactly on board on that many years ago when—and Marty is smiling—I was not on board on that many, many years ago because, like many, I was very skeptical that we might have such problems that have been mentioned, the veterans would suffer or the Air Force folks would suffer or whatever, but my whole existence is veterans and I think now, today, that they have worked an awful lot of things out.

There seems to be many changes. We do not see as many children and some of the military folks understand that we are veterans. We may not have stars and bars and things on our shoulders, but when you arrive in that facility, if it is an active-duty person that is working the urgent care facility or whatever, veterans should not wait behind some colonel or general. We hope they have that message. It appears to be going that way.

I had the unfortunate circumstance of having a son home on active-duty leave over the Christmas holidays and he did get ill. We took him out to the VA hospital. The VA was very good with him. We brought him over to the Air Force side, and I will tell you this kid, serving in the Coast Guard, I thought he was a general in the Air Force. But they knew he was on leave and they took good care

of him on the Air Force side: expediently, medicine, physician, the whole nine yards, and got him out of there.

I would like to leave some time for questions and not keep everybody here all afternoon, Mr. Chairman, Congressman Schiff, so I would conclude at this time my testimony and yield to any questions that you may have.

[The prepared statement of Mr. D'Arco follows:]

STATE OF NEW MEXICO
VETERANS' SERVICE COMMISSION

BRUCE KING
GOVERNOR

P.O. BOX 2324
SANTA FE, NEW MEXICO 87503

MICHAEL C. D'ARCO
DIRECTOR

State of New Mexico

October 8, 1994

Messrs. Chairman and Members of the Committee.

Thank you for the kind invitation to present the views and observations of the New Mexico Veterans' Service Commission.

The Commission is an independent agency and interacts with many of our great state's 175,000 veterans, and their families. Our role is to provide veterans with benefits assistance through our sixteen statewide offices. In addition we also manage a conservatorship program, and serve as federal payee or court appointed conservator for nearly 300 veterans who have been found by the U.S. Department of Veterans Affairs to be incapable of self management.

We, in the commission, wish to applaud your committee for your concern for veterans by conducting this hearing in New Mexico, thereby, allowing local individuals the opportunity to make presentations. Otherwise many speakers would not have been able to visit Washington.

In keeping with the chairman's request, I am pleased to transmit my perception of U.S.D.V.A. medical services. As both State Director of Veterans Affairs and a patient of medical services, I feel very qualified to do so.

First, in nearly eight years as director, I am pleased to report that seldom does our commission, or its staff receive any complaints concerning health care delivery about the U.S.D.V.A. Medical Center.

In my capacity as director I make frequent trips to the medical center, and I often question patients about their appointments, or stay at the facility. In addition, I have a field office at the center staffed by two full time employees who also by virtue of their location have daily contact with patients and staff.

Like everything else, nothing is perfect and so one does on occasion encounter a problem. However, my experience as a professional has always found the medical center staff willing to resolve any problem area.

Rural Clinics:

One realizes that one of the leading issues and concerns in health care is accessibility as well as quality. Here in New Mexico as you are aware, there has been a great effort made to improve access to care. Over the past few years rural clinics have been established around out state allowing veterans easy access. Our vast land area has made it difficult for many to receive needed care from the only hospital in our state located in Albuquerque, but that all has now changed with the new clinics. In addition the V.A. Medical Center--Albuquerque has seen to it that there is always an open line of communications with veterans and their organizations. During regularly scheduled meetings held at the medical center, veterans organizations staff are given the opportunity to meet with Mr. Harwell or an associate director.

I am also pleased that the medical center director is very accessible and has a willingness to listen.

Patient Care:

On the personal side, I would assure you that the best possible care is being provided. I myself have undergone two major bone surgeries at this facility, as well as rehabilitation. Today I am pleased to report an excellent recovery, to the credit of first class surgery and physical therapy second to none.

Rehabilitation:

As I have stated from a personal view point, no words can express my gratitude for a full recovery and a job well done. The staff performing physical rehabilitation are dedicated, hard working, professional individuals. Their dedication is second only to the kindness and friendship that bonds them to each patient.

Public Law 96.466:

I would also like to mention that I have the honor of serving on the Veterans Advisory Committee on Rehabilitation which was established in 1980 by PL. 96.466.

The committee is charged with: Assessing the rehabilitation needs of disabled veterans, reviewing the programs and activities of the Department of Veterans Affairs designed to meet these needs, and offering recommendations to Secretary Jesse Brown, concerning the administration of veterans rehabilitation programs under title 38.

Quite incidently the committee's most recent meeting was held here in Albuquerque, just two weeks ago September 18 - 20, 1994, and I am pleased to inform you that the committee was quite impressed with the delivery and quality of care at both the Spinal Cord Center and Medicine and Rehabilitation Physical Program.

Comparisons presented to our committee by VAMC Albuquerque, clearly revealed that Albuquerque meets, and in many areas is far superior to, other V.A. rehabilitation medicine departments. As an example, the average length of stay for ortho, stroke, and pain rehabilitation patients is less than that of other V.A. medical centers. However, more important is the end result. Albuquerque has a higher discharge rate of patients to the community (as opposed to discharge to other facilitiea) than the other centers. As a committee member for more than five years, I have had many opportunities to compare facilities. In that respect, I have been a veterans advocate for nearly twenty years, having also served as a U.S. Senate staff member for seven years, and as a service representative for the American

Legion. I currently am the Vice President of the National Association of State Directors of Veterans Affairs, and I can assure you that veterans in New Mexico receive priority and quality care. If they don't, Congressman Schiff can assure you I would be the first to yell.

Mr. Chairman, I thank you again and this concludes my testimony.

Mr. TOWNS. And the red light is on.

Mr. D'ARCO. Good thing I looked.

Mr. TOWNS. So we now move to you, Mr. Montoya.

Mr. MONTOYA. All right, sir. I first want to thank Congressman Schiff and you, Chairman Towns, for the opportunity to express our views regarding medical care here for our ex-POW's. We have approximately 700 POW's in the State. I want to stress—it would take too long to read the whole testimony so I will not be able to touch on all of it, so I will highlight some of the views that I have.

My problem is that, it appears to me, that the VA does not really focus on ex-POW's the way they should, because I think POW's, ex-POW's, like myself, have special needs that are not recognized. And so, for that reason, in 1981, the Congress passed Public Law 97–37, which is very appropriate and is really more liberal than what we had before.

Under this law veterans may when applying for disability expect that presumptives can be used. In other words, the doctors can go on what all the different diseases that are incurred in prison camps and use them to document that they are in fact service connected. But it is not happening that way. The doctors continue to ask for documentation that is very scarce and almost nonexistent from POW camps.

One other thing in connection with that is that here in this hospital we do not have a medical ex-POW coordinator. The VA has problems with these assignments. It always seems to be like a real difficult problem to get a medical coordinator here that will be there for any length of time. What happens is also there is very little coordination between the administrative coordinator and the medical.

I stress that because I think if there was coordination we would have a better operation for our ex-POW's.

I don't want to sound negative, but these are concerns that we have—there is less people getting compensation here in this State than any other State of the Union. This is a fact. So what is the reason? I don't know what it is, but I think it ought to be corrected.

And on a more positive note, we have the satellites out there in different parts of the State, which were needed for a long time. New Mexico is very rural and we need those services. I have been to the Farmington Clinic and to the Gallup area and they certainly serve a lot of people there. I don't know about all the different satellites that they are going to have, but it seems to me that at a point in time they will need to be consolidated as Congressman Schiff said, because otherwise it will be too expensive to operate that many.

Also there are other things we think are needed right here in the hospital. For example, in talking with some of the social workers we felt that a day care center is needed for veterans, and for POW's would be something that the hospital could start for ex-POW's. When next-of-kin come to visit there is no privacy for them; and we felt that if there were a day care center, there would be more privacy and families would be able to communicate better.

Last, I want to say that the hospital does deserve a lot of credit for the satellite clinics for the spinal injury and this and the other, but I still think that the transportation system could be better. Were it not for the volunteers, we could not have any transportation services. That is all I have.

[The prepared statement of Mr. Montoya follows:]

Good Afternoon ---

I want to thank Congressman Schiff and Chairman Towns of the Subcommittee on Human Resources and Intergovernmental Relations for the opportunity of expressing my views concerning the quality of care provided by the VAMC of Albuquerque.

Since most of my paper deals primarily with treatment of Ex-POWs, I will preface it by listing a few of the diseases and/or health problems endured by Ex-POWs during capitivity. Malnutrition was a given in most camps. This condition resulted in a lowering of resistance to fight a number of diseases which included malaria, pelagra, dysentary, bari beri, frostbite, truamatic arthritis and others. In addition, many suffered from injuries which occurred during combat and from beatings by enemy soldiers in prison camps.

Despite these adverse conditions experienced by most Ex-POWs it has been and continues to be exceedingly difficult for POWs to satisfy Physicians that their disability and/or illness is service connected. VA Physicians always ask for documentation even though POW Camp records are scarce to non-existant.

Special needs of Ex-POWs

Long after WW II ended, the U.S. Congress finally realized that the terrible conditions experienced in the prison camps are responsible for the plight of the Ex-POW today. This realization prompted the passage of Public Law 97-37. Yet it appears that our VAMC has not yet learned this, judging from incidents such as the following: In the month of February 1994 Irving Ehrens' was participating in an occupational therapy program where he was taking a class in ceramics. He was told that he could not continue in this class. The reason given by VAMC was Irving was endangering other members in the class because he is legally blind. I offered to help Irving and ended up writing a letter to the VAMC Director. I charged that VAMC was in violation of PL 97-37. Mr. Harwell's response was that the District Council had denied the charge. I was unable to appeal the decision.

Public Law 97-37

The passage of this legislation liberalized, to some extent, benefits for all Ex-POWs. I have listed five of the provisions of PL 97-37 which have not been fully implemented by this VAMC and which would certainly add quality to the lives of our comrades: (1) PL 97-37 makes possible for them to have disabilities service-connected on a presumptive basis. It is clear that the medical center is not using this approach. It is ironic that even though this law increased presumptives to 19, we still have so many Ex-POWs who are in bad shape yet are not entitled to compensation. (2) This law requires Medical Centers to ensure the timely delivery of services to all Ex-POWs. This provision, for the most part, is not being fulfilled. Few clinics abide by it. It is not uncommon for Ex-POWs to wait as long as 3 to 4 hours. (3) Appointment of an Ex-POW Medical Coordinator has always seemed to be an administrative headache for our VA Medical Center. The person who is holding that position at the present must also consider the coordinator position a headache because she has failed to inform us that she is officially filling that position. (4) Mr. Joe Valdez is our Physician Assistant who takes care of us at the Ex-POW Clinic. Although he is not an M.D., he is very good at what he does; and relates very well with us POW's. (5) Our Ex-POW Administrative Coordinator is Mr. Fernando Martinez. We consider him an advocate. We know we can count on him for help; but frankly, I don't think he is

provided enough time to effectively accomplish this job. I think this is a full time job.

Transportation

The area served by Albuquerque VAMC is extremely large. It covers all of New Mexico, parts of Texas and Colorado. A VAMC that covers such a large area should spend more funds for transportation.

Vans are bought by the New Mexico State Department of Disabled American Veterans. Then titles are transferred to VAMC which provides fuel and maintenance for them. VAMC uses volunteers to take patients to and from VAMC. Volunteers are paid about 25 cents a mile for providing their own insured vehicles and driving them. This is all they receive for their valuable contributions.

Another fault with the system is inaccurate scheduling. This causes veterans to miss appointments or miss the bus that will get them back home in time.

The Medical Center deserves a lot of credit for having managed to enact five clinics in the rural areas of New Mexico. I have been to Gallup and Farmington to form a POW Chapter. Each is staffed by a parttime Physician, a registered nurse, and a medical technician.

These clinics are a blessing in these communities. Heavy use is already causing delays in the delivery of services.

Fernando Martinez, Social Services Supervisor visits these clinics when he can find the time.

Day Care for Veterans

My visits with staff personnel sometimes turn into what I consider a very good exchange of ideas that could help to improve the services to veterans.

During a recent visit with one of the Social Workers he and I were trying to come up with some ways to enhance the VAMC visits by next-of-kin to the veteran. We agreed that couples would enjoy these visits more if they could have a little more privacy than they have in the wards or halls of the Center. We think some kind of Day Care Program for Veterans would provide more privacy. A place where they could feel at home even for a little while.

I hope that my testimony in some small way may help to improve the quality of life for veterans. I believe our VAMC can do this if we, as veterans, are willing to help.

Ben Montoya
National Director
Southwest Region
American Ex-Prisoners of War

Mr. TOWNS. All right. Thank you very much, Mr. Montoya.

Ms. Cox.

Ms. COX. Good afternoon. Thank you for inviting me to appear before you this afternoon on behalf of women veterans. I will try to summarize my written-out notes.

There is a button being worn by some of the staff at the veterans' hospital that say, "Women Are Veterans, Too." This is something we should not have to wear. It is a benefit that should be granted to all veterans and women should not have to be in a position where we should have to tell people. It should be a known fact.

In order to get the word out to the women veterans, we need to enroll the women into the system, even if they do not require the medical treatment at that time. The director needs to know the kind of people that are going to be asking for help. And if they do not know how many women are in the area ahead of time, they could not very well prepare for that.

They did open the women's clinic in May and that has opened the door for a lot of the women veterans to seek treatment. But one of the main things they are complaining about is the routine examinations that are done to men cannot be transferred literally to women because there are other things they need to do, like the pelvic exam or mammography exams they need to do on women if they are admitted to the hospital.

If they are being seen at the clinic, then it is a matter of routine. Those women are having those tests done. But if a woman veteran comes in and she does not have any insurance or she has another type of insurance and they have not been seen at the hospital before, those are not part of the routine. Unless the doctor himself asks for it, they will not be done. And the women's clinic is available and they will do the tests if the admitting doctors refer them to the clinic for that.

Another area is the sheer numbers. Women are joining the military at a stable rate. I think some of the figures I have is 11 percent of enlisted rank and 12 percent of the officers. And add those numbers to the women veterans from World War II, Korea, Vietnam, Desert Storm, and the numbers grow and grow; and add that to the men, and they are asking for help, they are asking for other treatments, and so are the women, and we want to be included in those numbers.

Everybody is living longer, men and women, and in old age we have medical problems. The older people get, the worse the medical problems get. And if the women are going to be asking for medical benefits, the men are also going to be asking for medical benefits, and the funds need to be provided to make sure they are available.

The cancer study that was promised to women, I think in 1992, and I am hoping I have this accurate, I think I have the right date on there, that has not been done because the necessary funding has not come through. That needs to be provided.

We are grateful to Secretary Brown that he did form a Women's Program Office at the VA, but we need a permanent women's bureau, because we know that Secretary Brown is interested in women veterans, and as long as he is in office we know that he will do the best he can. But we are not very sure of what will happen

when succeeding administrations come in and if they do not place the same type of priority to women veterans.

And I think I beat the light.

[The prepared statement of Ms. Cox follows:]

COMMITTEE HEARING

SUBCOMMITTEE ON HUMAN RESOURCES
AND
INTERGOVERNMENTAL RELATIONS

ALBUQUERQUE, NEW MEXICO
OCTOBER 8, 1994

"WOMEN ARE VETERANS TOO"

This slogan is on the buttons worn by the staff at the Albuquerque Veterans Affairs Medical Center Women's Health Clinic. The Women's Clinic opened May, 1994 and is a giant step forward in providing the care for the women veterans who choose the VA for their medical needs. Privacy is a major problem, but this separate clinic provides the necessary privacy at the outpatient level. For women admitted to the hospital, there are rooms in the wards that have private baths.

In order for women veterans to start using the VA Hospital , they must enroll and apply for medical benefits. Early enrollment is necessary so that the Hospital Director and his staff will know as much as possible about the people for whom they are accountable. A veteran should not have to be sick in order to enroll and find out what services are available. Being sick is stressful enough without having to deal with the amount of paperwork that the government collects when a veteran seeks treatment.

Physical exams including pelvic exams and mammography exams for inpatient women is another area that needs to be addressed. Here in Albuquerque, the physical exams can be done at the Women's Clinic if the admitting doctor requests it. If the woman is already being seen at the Women's Clinic, these exams are already being provided. The women that are admitted to the hospital under another health plan or with no insurance might not have their yearly exams up to date.

Since the downsizing of the military began several years ago, the numbers of active-duty billets occupied by men have decreased more rapidly than those occupied by women. The result is that women now make up about eleven (11) percent of enlisted ranks and twelve (12) of officers in the active forces. The willingness of young women to enlist has always been relatively low but has remained stable. These women will be seeking their benefits as veterans in the near future. Add those numbers to the women veterans from World War II, Korea, Vietnam, and Desert Storm and the demand grows.

Men and women alike are living longer thanks to medical science and research and the elderly population is increasing dramatically every year. Veterans need access to a wider range of medical care including geriatric evaluation and management programs. This puts a big demand on the already strained VA system. Congress needs to recognize this and allocate the funds necessary to provide quality medical care to the elderly.

The Women Veterans' Health Study in the Veterans Health Care Act of 1992 has been delayed long enough. The necessary funding for Cancer Study in women needs to be allocated so that some progress can be made in this research.

When Secretary Brown appointed Joan Furey to head its newly formed Women Veterans Program Office, it helped by ensuring the consistency of programs which provide services to women veterans. This is a step forward but we need a permanent Women's Bureau within the VA to ensure that past accomplishments in women veterans services are not eroded. There have been some significant improvements in the VA's attitude and treatment of women veterans during recent years but deficiencies still remain in many areas. It is vital that additional legislative steps be taken since we do not know if succeeding administrations will place the same degree of priority on women's issues.

Mary Chavez Cox
October 8, 1994

Mr. TOWNS. Right. Thank you very much. I appreciate your testimony.

Let me begin, I guess with Mr. D'Arco, by asking you, since you talk to veterans a lot in the nature of your work, do they complain about waiting time and scheduled waiting time for appointments? Do they talk about these problems that much.

Mr. D'ARCO. Not with me, Mr. Chairman. I am not getting that kind of feedback from the veterans in the field.

Mr. TOWNS. What kind of complaints do you get from the veterans?

Mr. MONTOYA. The same question?

Mr. TOWNS. Yes; the same question.

Mr. MONTOYA. Here in Public Law 97–37 it states that ex-POW's should receive priority service. In other words, they do not need to sit and wait a long time. It happens on location a lot that most of the time that ex-POW's do not receive priority service.

Mr. TOWNS. You are talking about service connection disability?

Mr. MONTOYA. Yes, the service connection. We are not allowed sufficient time to talk to VA staff about some of these problems, about services that we do not get and that are there covered under Public Law 97–37. It is not being recognized or adhered to.

Mr. TOWNS. Right. Just on that point, and then I will come back to you. They can appeal; right?

Mr. MONTOYA. Oh, yes; we have done that. We are appealing these things. But like everything else, it is a long time before these things are looked at.

Mr. TOWNS. In other words, the appeal process takes a long time?

Mr. MONTOYA. Yes; it does. Yes; it does.

Mr. SCHIFF. Mr. Chairman, would you yield for 1 minute?

Mr. TOWNS. I would be glad to yield.

Mr. SCHIFF. We are talking about the compensation determinations, Ben? Is that what you are referring to here, or in the hospital?

Mr. MONTOYA. Yes, that is part of it—like any other concerns that we have.

Mr. SCHIFF. I ask because that is separate. It is under the VA, but not under the hospitals. I was just wondering which areas we are talking about here.

Mr. MONTOYA. When I said that they did not respond to us, that we can go and we are treated like anybody else. We have to sit and wait maybe 3 or 4 hours. Appointments may be hard to schedule. For example, I have to see an orthopedic doctor about maybe every 4 or 5 months. So I asked for an appointment the other day and they said, well, we will get you one sometime in January. I realize that there are a lot of people trying to get in, but it seems to me like that is an unduly time to be able to see a doctor.

And then, also, we have a doctor, we have PA filling the position of an M.D. in the clinic for ex-POW's. That is not in line with 97–37 either.

Mr. TOWNS. The physician assistant is actually filling the position of——

Mr. MONTOYA. Of a doctor. Of an M.D., right. And the medical coordinator that has been appointed now has not even met with us

or called to talk with us, and it has been like that 4 or 5 months. Before that, the man that was the coordinator was moved to another part of the hospital and it took every bit of another 3 months before they filled that position.

Mr. TOWNS. I think I understand what you are talking about. I think you are talking about two things, if I understand.

One, you are talking of compensation, in terms of disability; but the other thing you are talking about are in the clinics, if you request an appointment at a clinic, they give you a date that's way down the road.

If you indicate the fact that you are an ex-POW, do they at that point review or revisit it and then say to you that, OK, we will be able to cut the time? Or would they just say to you, well, I am sorry, this is just the first available date?

I am trying to make certain I understand what you are saying.

Mr. MONTOYA. Well, we have a scheduling system at the VA, so when you call in for an appointment with a doctor, this person who is doing that will give you an appointment. So, really, you can tell him I need to see something quicker and he says, well, come into urgent care. And most of the time if you go to urgent or emergency care they will not take you in because you are not an emergency case.

Mr. SCHIFF. Thank you, Mr. Chairman.

Mr. TOWNS. Well, back to you Mr. D'Arco, on the complaints. You wanted to say something.

Mr. D'ARCO. In line with what Ben is saying, Mr. Chairman, there is a long period of waiting. It seems to be that when you schedule—and that goes back to the staffing again—the scheduling could be 2 or 3 or even 4 months down the road.

But I was going to mention it, and Ben touched on it, with the orthopedic clinic, my experience is, and that is one of the busiest clinics, that I have not waited longer than a couple of hours. I would like to say I disguise myself. I do not go in wearing a name tag. I try not to wear a suit, especially if I go in in the morning or whatever, if I drop into a clinic. But on the scheduled appointments, I am in and out without anybody knowing who I am.

But Ben is probably on the mark with the appointments. It takes them some time for everybody. They should not, however, take time for the POW's.

Mr. TOWNS. My time has expired. Congressman Schiff.

Mr. SCHIFF. Thank you, Mr. Chairman.

Mike, I read your written testimony, and I do not want to misquote you. It is my understanding is that looking at this veterans medical center as a whole, allowing for the fact that every institution has its day-to-day problems, you give it pretty high marks. That is what I am gathering. Am I right about that?

Mr. D'ARCO. Yes, sir, I do. Congressman, like you, I invited the Secretary's Advisory Committee on Rehabilitation to visit this facility, and with no intent in mind that there was something wrong with it. There are a lot smarter folks on that committee than myself. Dr. Betts, for example, from Chicago and Ron Drack, one of the real movers in the disabled American veterans area in Washington, DC.

I think, overall, and you have known me a long time, I worked in the Congress for 7 years. I have had problems with them in the past, but, overall, from my experience and traveling to other VA medical centers, and I visit two to three VA medical centers per year for Secretary Brown, and have done that for more than 5 years, I credit this facility.

I do agree, we have problems, we have staffing problems and funding problems, those kinds of things, but for the most part, I think it is a pretty fair facility.

Mr. SCHIFF. Ben, let me ask with respect to specifically the POW's. I have to concede what is obvious. Congress is able to pass laws rather easily that direct agencies to follow certain actions. They do not always pass the funding behind it to make that possible, I am sorry to say.

But specifically within the subject you have mentioned and the group of veterans you represent, the ex-POW's, I believe you were in the room when Director Mike Harwell answered my question about is there some people in the organization that patients can talk to if they feel that there is something, a problem that needs to be examined, and I wanted to ask, have you brought this to the attention of the officials in the administration who are responsible for responding to patient matters to see if there is anything they can do to come closer to loosening up the ex-POW's in the system?

Mr. MONTOYA. Well, I probably have not been as consistent in doing that as I should, but I have asked for them to meet with us so that we can let them know what it is that we are entitled to. There have been laws passed.

A lot of POW's do not even know what to expect. That is why we need to meet with them. They never call us to meet with them. So far as being able to contact, I have the contacts. I talk to people on Mr. Harwell's staff, like Mr. Bunch, I think he is here. I have asked him to call us in so that we can talk about some of our problems. It was done for a while, but then it has been discontinued.

So it is not an easy thing, Congressman. And like Mike said, I understand the problems, lack of funding and a lot of things, they cut the funds. There are less people to serve you, and I know that makes a difference. But it does seem to me that there that leaves a lot to be desired insofar as following up on some of these things over a long period of time that are not addressed. Some of these problems reoccur.

Mr. SCHIFF. Well, I just want to suggest that if it has been a while since you and the ex-POW's have requested a meeting with the administration, my respectful recommendation would be to request one as soon as possible, and I think bring everyone up to date and I am sure it will be received.

Mr. MONTOYA. I will do it as soon as possible. I don't want to belabor the point, but the lady that is now filling the position of medical coordinator, I have asked her if we can meet with her and there has been no response. She says, "well, I will look into it," But she never calls us to meet with her.

Matter of fact, we did not even know when she was installed at that position. We knew it was open. It took a long time to learn that she was the person.

Mr. SCHIFF. I have the strangest feeling if you ask again a meeting will be set up pretty soon.

Mr. MONTOYA. We do not give up. We know that we have to do that in dealing with the VA.

Mr. SCHIFF. Ms. Cox, Mr. Harwell, of course, in his testimony, responded in advance of your testimony to the knowledge, of course, that more and more women veterans are coming into the system because more and more women are passing through a military career, naturally.

I had the feeling, perhaps I was wrong, but I had the feeling you were speaking in generalities.

Ms. COX. Yes.

Mr. SCHIFF. Which is fine, and we appreciate that testimony, but I would like to ask, in your own experience, or experience in discussing matters with women's veterans, have you had any specific reports, favorable or unfavorable, whatever they might be, about this particular veterans medical center's response to women's patients?

Ms. COX. The one I have made on a personal basis would be the one on enrollment. But I have already talked to Mr. Harwell and the VA and they are working on it. I tried to enroll twice, not seeking medical treatment, but to put my name into the system, and both times they said, no, we cannot do it.

To me, that is why I am pushing for early enrollment. Because if they do not know how many women would seek help, if they are going to keep the women's clinic and they know they have, say, 5,000 women that would use it, that would help a lot; versus now, they have about 500 they have treated, but they do not know how many women are out there. Early enrollment would help that, and they are going to change that. They are going to take enrollments, even though we are not going to be seeking treatment at the time.

Mr. SCHIFF. So they have agreed to accept your suggestion?

Ms. COX. Yes, I am going to go down and start filling out the paperwork, so that will help.

Then the outreach to women, to get the word out that it is available and go in ahead of time, that another problem. They do not know how many women's veterans there are even in the whole State, or probably in the region, and we do not know where to go to get those numbers because the numbers were not kept. Somebody has them, because the records are somewhere, but they have not been split-up. We need to be getting the word out.

They have a newsletter, like Mr. Harwell said, at the VA. But unless you go in for treatment at the VA, you never get the word. So we need the funds or something to put the word out.

Karen Pierce has been very good about trying to get the word out. Every time we have functions to do with women veterans she is there with her paperwork trying to get the word out to women, and it is amazing how many women do not know they have benefits available to them. Some know they have them, but do not know who to reach. You have to take them by the hand, I guess.

Some women are under their husband's plan and never seek it, but maybe they would——

Mr. SCHIFF. And early enrollment does not cost anything.

Ms. COX. No; but the VA needs to have an idea of the number of people.

Mr. SCHIFF. Of the potential workload.

Ms. COX. Yes.

Mr. SCHIFF. Well, I want to thank all the panelists and I would yield back, Mr. Chairman.

Mr. TOWNS. Before you go, I want to ask Ms. Cox another question. I had an opportunity during Desert Storm to go over and to visit and to see all these women who were involved in Desert Storm. And you made a comment that made me sort of reflect back on that. You said more needs to be done legislatively on behalf of women. Could you be specific?

Ms. COX. On the women's bureau?

Mr. TOWNS. Yes; actually, in your testimony you said more needs to be done on behalf of women legislatively.

Ms. COX. Well, the office that is in there, I think, I guess you would call it an appointment?

Mr. TOWNS. Yes.

Ms. COX. But we need a permanent one in there. I guess Congress would be the one that says it is a permanent office within the VA, a women's bureau. That is what I was talking about.

Mr. TOWNS. OK.

Mr. SCHIFF. May I get in one extra word?

Mr. TOWNS. Sure.

Mr. SCHIFF. I just wanted to mention that Ms. Cox is working with my office on the annual tribute to the women in military that we are putting on. And by the way, we have done this every year I have been in office, and I took it over, because my predecessor, Manuel Lujan, put on this program to focus on issues related to women in the military. And I think this would be an excellent subject to emphasize in that program. And between the two of us, I trust it will get done.

Ms. COX. Yes and thank you very much for the help on the tribute.

Mr. TOWNS. Let me ask you this question. Have you found, in terms of this block scheduling, blocks of time, that the females have to wait longer than the males?

Ms. COX. That, I cannot answer right now. That was not one of the things that was brought up. It was more like on the bedside manners on doctors than the waiting time to get in that I heard more. But the time to see a doctor, I did not hear that.

Mr. TOWNS. Well, let me say that I know in terms of special kinds of needs, and I have been very involved in terms of that in Washington, DC, regarding mammography in particular. That was an issue we looked at in terms of making certain that these kind of services were there under health care reform whatever we decided to do. So I will still continue to look at it even in this area as well.

But let me thank all of you for your testimony. Here again, I think that what we see here on this end is something that we can all learn from. I am hoping that other places will begin to model themselves after this program. And, to be sure, whatever you do, there will always be some problems. But I think as long as you are

talking and working together I believe you will be able to come up with a solution to the problem.

I want to applaud you for the work you are doing on behalf of women in terms of making sure they are recognized in terms of their work, because, I will be honest with you, I consider myself a person that follows the military very carefully and closely, so I know what is going on. But when I went to Desert Storm and saw in terms of the amount of females involved, and in combat situations and all that, I tell you, I really was just shocked as a person who served in the military for a number of years.

So it is a change and I think we have to change along with it to make certain that when they come out that they are veterans, too. Thank you very much.

Ms. COX. Thank you.

Mr. D'ARCO. Thank you, sir.

Mr. MONTOYA. Thank you.

Mr. TOWNS. Our next panel is Tod Cornell, commander of the Korean War Veterans Association. Would you please come forward; and John R. Shipley, director of social services, Vietnam Veterans of America, please come forward; and Juan Urioste.

Mr. SCHIFF. Mr. Chairman, we did not receive confirmation of Mr. Urioste's testimony, so this may be it, this complete panel.

Mr. TOWNS. OK, fine. Why don't we start with you, Mr. Cornell. Welcome.

Mr. CORNELL. Thank you very much.

Mr. TOWNS. As you probably heard, your entire statement will be included in the record and we would appreciate it if you can summarize within 5 minutes so that we may have time to raise specific questions with you.

STATEMENTS OF TOD D. CORNELL, COMMANDER, KOREAN WAR VETERANS ASSOCIATION; AND JOHN R. SHIPLEY, B.A., M.DIV., DIRECTOR, SOCIAL SERVICES, VIETNAM VETERANS OF AMERICA, INC.

Mr. CORNELL. Be more than happy to. Congressman Towns, Congressman Schiff, ladies and gentlemen, thank you for the opportunity of addressing the group today.

I titled my remarks, "Make the Bloody System Work." And you heard all kinds of comments made so far today and they have all skirted around one big issue and nobody has put their finger on it yet. So if I may, I would like to slide my remarks aside and get down to the specifics.

We have a very unique and interesting State here in New Mexico. We have 66,000-plus veterans in Bernalillo County, 176,000-plus veterans in the State of New Mexico. We have 99, possibly 100, one-, two-, and three-star generals and admirals that live in this State, plus four astronauts and four Congressional Medal of Honor recipients, of which three are from the Korean war periods.

Next June marks the 45th anniversary of the Korean war. I organized a salute to the Korean war veterans last year and had an Albuquerque salute to the Korean war veterans with 135 veterans marching home 44 years and some odd days late to get their salute home from a conflict that everybody has completely ignored.

We have three basic fundamental groups of people in this market and that is the World War II older veteran that needs long-term care, in-house care; the Korean war veterans, which is the middle crowd and coming up very quickly into that category age-wise; and the Vietnam on down to the younger era that has a lot of outreach problems and what have you.

As I said in my testimony, we have a good medical system here. It is one of the better ones. It does a good job. Unfortunately, there is a lot of rust within the system that costs money that could be put into medical service and medical care.

I talked to some of the medical people at the VA facility off the record because that is the only way they will talk to me, and I say what is the biggest thing you would like to see changed? By and large, it is eliminate the paperwork, eliminate the bureaucracy, and let me do what I am hired to do, which is provide medical services and medical care.

Now, New Mexico has an interesting problem, a spinoff on this thing, is that we have a large Native American population. New Mexico was the first State in World War II to lose its entire National Guard with the fall of Battan in April 1942, and that was 2,000 people in that group, Anglos, Hispanics, and Native Americans. And we have a diversified cultural background, a diversified values system, and a diversified communications system, and we have a very good VA program out here that could be better if it was funded and had more people providing services in the field, eliminating the bureaucracy, and allowing the people who work on the local level to do it on the local level; but, above all, concentrate on marketing.

We have, as Anglos, a horrible time trying to understand government speak in the system. We have a lot of veterans who have English as a second language.

Now, I went to a meeting, and I found something that I was not aware of. It was called a VAMC health summary in the computer. I didn't know about that. So I stopped off at one of the offices and I said do you have this puppy? I want to see it. They cranked it up and I said, "Interesting read. Can I take it home with me?" Good God, I might as well have asked for a million dollars. A person really got horribly upset.

But when I thought about it, I said, ah, I know where to go and talk the VA language speak. No problem. I can get into my records. But when you have a lot of people that do not understand how the system works, and why you have to go to A instead of B, or why you cannot get the services as fast as you want, it is no wonder that the poor indigenous veteran in the community says, hey, Bro', I did my best for God and country, now the system does not want to take care of me. And it hurts. It is difficult to work with. But we are trying our best.

Now, one of the things that I think would be absolutely beautiful would be if we could get a little seed money to develop a good marketing program in this area and we can use the existing media ve-

hicles to tell the tale, tell the story, get the information out in a language we can understand. Then Mr. Harwell's customer count is going to go up and the system really will get off its bloody duff and work. Thank you very much.

[The prepared statement of Mr. Cornell follows:]

MAKE THE BLOODY SYSTEM WORK

Tod D. Cornell, Commander
Korean War Veterans Assn., NM
242-B Rhode Island, NE
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2 October 1994

Here it is ... Sunday morning and I have to turn this in tomorrow morning. I have gone over this material six times, talked with more people than I do in a month ... and now I am redoing my remarks again. I know the other guys are going to tout the system and their part in the total mix. How to get my message across without writing "War and Peace" all over again ... I know ... **the rule of KISS !!!**

Congressman Towns, Congressman Schiff, Congressman Mica; ladies and gentlemen. I am honored to present my views of the **VAMC** (Veterans Administration Medical Center) in New Mexico. As organizer and Commander of the Korean War Veterans Association in New Mexico, I have enjoyed working with the men and women that have fought the battles of this country over the last seventy-five (75) years. The Greater Albuquerque area has over sixty-thousand (60,000) veterans from World War One thru the present day operations in the Caribben.

In general, the medical services of New Mexico are of top quality and meet the needs of the veteran community. The VAMC needs to be "fine tuned". The outpatient clinics should be expanded and new units added. The same holds true for the many programs that are offerd. We have a good staff of professionals that are trying to meet the needs of the large veteran community in New Mexico. If the system is so good...what is the problem? In my view, there are two major areas and I doubt if the "system" is paying enough attention. One is the nature of the customer and the other is communication; aka marketing.

The veteran population in the Southwest is different. It is made up of Native American, Hispanic, Anglo and other ethnic people. The cultural, economic and educational background is as different as the people that make up the groups. Many of us who are active in the veteran community, have seen unhappy veterans say: " I don't understand, I did my bit for God and Country. Why can't I get help?." As leaders within the community we try to help, but are more apt to find the veteran walking off muttering a few things that I would not care to put into the Congressional Record. The word on the street is MAKE THE BLOODY SYSTEM WORK !!!

Like it or not, the VAMC system is in a competative world. The VAMC does not effectively communicate with its customer base. That means marketing !!! Marketing the services and marketing the "language" of the system. To illustrate my point, I found that the local VAMC had a "health summary" in the computer. This was news to me, so I asked for a copy. I would have had better luck asking for a million dollars. Once, I got into their "language" mode ... no problem.

In order to teach language and let the veteran know what is available, a mass media vehicle should be developed. It could be print or electronic. We have local talent that can conceptualize the project. With proper programming mix, the local veteran service organizations could support the effort. If it plays in Albuquerque, it will play nation wide. However, to get the concept up and running, a small R&D Grant would be helpful.

I feel that the VAMC system does work in New Mexico, once you learn the "language" of the system. Since English is a second language for many of the people in this area, and the Anglos are

having trouble learning the VA lingo ... it's really no wonder that the veteran feels and reacts the way he does.

I must add here that the VA system generates more paperwork than it really needs. It has been this way since the birth of the Veterans Administration. My father passed away in 1939, I was able under the Freedom of Information Act to get his "C-File". It came in three LARGE packages. When I clean the mass of documents up, I expect to fill two binders.

I have followed the KISS principle because if I go any longer, no one will pay attention. I hope you elected officals will "fine tune" the system. If you need specific help ... I am available as a consultant.

Thank you very much for your time.

Tod D. Cornell
Commander, KWVA-NM

Mr. TOWNS. Thank you very much, Mr. Cornell, for your testimony.

Mr. Shipley.

Mr. SHIPLEY. Chairman Towns, Congressman Schiff, I want to thank you for the opportunity to appear on behalf of the Vietnam Veterans of America, the resource for peril center here in Albuquerque. I have submitted the written testimony regarding issues of medical care at the VA medical center and would like simply to respond to some issues that have been raised in the session here today.

Mr. TOWNS. Without objection, your entire statement will be included in the record.

Mr. SHIPLEY. No objections.

Questions were asked during Mr. Harwell's testimony about the quality of service of the VA medical center to homeless veterans, and I think he understated the effectiveness with which the VA medical center does address problems of homeless veterans. They are our largest client group by far, and we could pick out individual cases in which we could get adversarial, but I would want to point out the results in general of our referral of homeless veterans or at-risk veterans to the VA hospital for medical or other kinds of treatment have been largely satisfactory and we are confident that programs that they have not only effectively functioning at this time, but have indicated they are intent on delivering to the veteran community in the future are good programs, well thought out and delivered with the kind of thoroughness that needs to be done.

So I think Mr. Harwell may have been too modest on behalf of the VA's response to homeless veterans. Now, having said that and been nice on the one hand, I want to further point out that because the VA medical center is a medical facility, it shares in common what a lot of medical facilities have as a failing, and that is the belief that once the patient or client walks into the hospital, they must surrender all rights to whoever is in charge.

It was said to me 15 years ago when I first began working in the health care industry that once you entered the health care system you give up all your rights and there is a measure in which that is true. Maybe it is worse than a government-operated facility than in private or nonprofit facilities, but there is a tendency on the part of some medical staff related to the VA medical center to believe that they alone have the authority to decide issues of patient care and not enough time or attention is given to the concerns raised by the veterans themselves.

One of the things that our organization would like to see is what has been instituted in our organization. It is what is called a Veterans Advocacy Committee and that is a committee made up of people who have actually received those services, then talking directly to the people who deliver the services and telling them what was wrong with them or right with them. We would like to see some of that done on a proactive basis.

The other issue related to the care of the VA medical center that is of critical importance to us is what happens with medical records. One of the services our agency performs on a regular basis for our clients is to prepare and file disability and SSI claims before the Social Security Administration. And in order for those

claims to be adjudicated in favor of the veteran client we have to have thorough medical records, which sometimes exist only at the VA medical center, because many of the veteran clients that we have have not received medical treatment in any other facility other than a VA facility.

In working directly with the VA medical center here, as well as the Social Security System, we have improved the amount of time which heretofore will be required in getting those records from as long as 6 to 9 months upon written request from the Social Security Administration to down to where in some instances they are now available in much less time, sometimes as little as 2 weeks. But it is still an ongoing problem.

And related to that, our organization looks at clinical records from the VA hospital probably more intensely than most other organizations do, because we have a legal-medical consultant who evaluates those claims before we file them and turn them into the Social Security Administration. We see entries made into the clinical record by medical staff at the VA medical center that are no more than personal opinion, and in some instances these personal opinions by medical staff entered into those claims have ended up in social security adjudications and denials have been made based on that.

So we would like to see some sort of scrutiny with regard to whether entries in the medical records are truly clinical, and in some instances we know they have not been.

But, also, I would hasten to point out because of my role for many years serving as a minister, I visited VA medical centers all over the country. And, in fact, at one time I spent some time in New York. John Lindsey was there then. They called it fun city then. I do not know what it is called now. It may not be fun anymore.

Mr. TOWNS. We will talk about that.

Mr. SHIPLEY. OK. But, in my experience, the VA medical center at Albuquerque system is the most user-friendly VA medical center that I have been in. The dedication of the staff, I find, to be incredibly good. The responsiveness of the administration, when we make a racket about treatment of a veteran client, has been very good, and generally the thoughtfulness of the administration, we find, to be encouraging for long term. Thank you.

[The prepared statement of Mr. Shipley follows:]

INTRODUCTION

Mr. Chairman and members of the Committee, my name is John Shipley. I am Director of Social Services for the Resource and Referral Center of the Vietnam Veterans of America, Inc., New Mexico State Council. In addition, I serve as the Chairman of the New Mexico State Council Task Force on Homeless Veterans and as a member of the New Mexico Human Services Department Task Force on the Homeless. I want to thank you for giving me the opportunity to discuss the quality of care of the Veterans Affairs Medical Center in Albuquerque, New Mexico.

QUALITY OF CARE AT THE VETERANS AFFAIRS MEDICAL CENTER

Due to the range and scope of services of the Resource and Referral Center, many of the issues on which observations were requested fall outside the area of appropriate response. However, the general area of services in the hospital and in particular, services related to alcohol and drug treatment, psychological and psychiatric treatment, services to homeless and at-risk veterans, and ancillary services regarding medical records, are issues we deal with on a regular basis.

In general, we view the services provided by the Veterans Affairs Medical Center to be adequate in many instances. In others, specific and general improvements are desired and needed. Additionally, we have found the Administration and Staff of the Veterans Affairs Medical Center to be generally responsive to requests for additional or different services when requested by veteran clients of our office or members of our staff.

These general instances aside, though, there are areas of service which could be dramatically improved. In order to illustrate, specific case examples will be cited with the anonymity of the veteran client observed.

In one instance within the past two months, a veteran client was scheduled for an evaluation for the in-patient P.T.S.D treatment program. He arrived for the 7:30 A.M. appointment and was told that his appointment was "lost" in the computer. Since he did not have his appointment slip with him, he was re-scheduled for another appointment three weeks later. The problem created by this delay is that this particular veteran client had been pleading for evaluation and treatment for several weeks. Upon denial of acceptance for evaluation, decompensation was an immediate result. In critical cases of P.T.S.D., delay of introduction of treatment significantly exacerbates the condition. In this instance, the veteran client became dangerous to himself and others and, in fact, immediately became involved in an altercation with the police. Repeated calls to staff members of the Veterans Affairs Medical Center regarding this veteran client went unanswered.

In a second instance, a veteran client experienced major back surgery; the surgery was an L4-L5, L5-S1 discectomy, a laminectomy with free fragment removal; had extended rehabilitation, was discharged to the street, homeless. There was no neurosurgical follow-up and an MRI of his back in July showed major deterioration, scarring, nerve root impingement and impingement of the spinal canal with free fragments. The incident went without notice until the veteran client, accompanied by a staff member of the Resource and Referral Center, requested an update of the information related to the surgery. According to the attending physician questioned, there had been no orthopedic or neurosurgical follow-up on the MRI by the end of September. He now needs a second surgery.

In yet another instance, a veteran client who underwent extensive in-patient and transitional treatment for alcohol addiction and the resulting homelessness, was dischared from treatment with a ten-day lapse between treatment and available housing. The result is that he became homeless again.

In these three instances the veteran clients received satisfactory response/treatment at the initial stage of contact with the Veterans Affairs Medical Center. The problems began to accumulate as the duration of contact and/or treatment, and referral to other care-givers grew more extensive or complicated. The overwhelming majority of veteran clients accessing services through the Resource and Referral Center are dually dianosed and display multiple presenting issues. As the number and difficulty of presenting issues increases, the ability of the veteran client to access needed services decreases, usually in geometric rather than arithmetic proportions.

A recurring theme with many of these veteran clients is that whatever services have been provided are lost as they grow more and more frustrated with the system. The true measure of the loss includes the individual veteran clients who relapse into alcohol and drug abuse and resulting homelessness. It also includes the loss of resources utilized by the Veterans Affairs Medical Center where repeated treatment is required. In short, the lack of continuity of care results in a negative cost-effective utilization of resources.

ANCILLARY SERVICES AND ISSUES

Among the services provided by the Resource and Referral Center is the processing of claims for Social Security Disability and Supplemental Security Income, General Assistance, Food Stamps and referrals to Food Banks, as well as referrals to other care-providers. Without exception these services require complete medical records to substantiate claims of disability. The delay in receiving these records can and often does result in relapse into alcoholism and drug abuse, homelessness, decompensation into P.T.S.D., and psychotic episodes.

The lack of availability of medical records and the resulting denials of service, reinforces the feeling among the

veterans that no one cares, that nothing can be done, and that the situation is hopeless. Further, it reinforces their belief that upon completion of military service, all agreements regarding their care in the aftermath have been unilaterally nullified by the government they served.

POSITIVE CHANGES IN THE VETERANS AFFAIRS MEDICAL CENTER

Not all the news is bad news. The Veterans Affairs Medical Center is in the process of implementing the Primary Care Physician Model for veteran clients. This is viewed by the Vietnam Veterans of America as perhaps the most important innovation needed and desired. It will result in a team approach to care-giving by Veterans Affairs Medical Center staff including a Physician, a Social Worker, Nursing Staff, and other significant care-givers, as has been successfully utilized throughout the health care system.

The Primary Care Physician Model is, in the view of the Vietnam Veterans of America, most needed in the area of treatment of psychiatric problems. Our observation has been that veteran clients with these presenting issues are least capable of accessing appropriate services, least capable of inquiring about prescribed medication and possible side-effects, and least capable of self-awareness during and after treatment.

Additionally, it is hoped that the implementation of the Primary Care Physician Model will result in treatment of psyciatrict patients with therapy as well as medication.

COMMUNITY BASED SERVICES

An additional area of services which is welcomed by the Vietnam Veterans of America is the introduction and emphasis being given to community based services, including those under contract to other service providers. It is believed that cost-

effectiveness will mandate expansion of this important effort by the Veterans Affairs Medical Center. Additionally, the entry of the Veterans Affairs Medical Center into community based services is warmly greeted by overburdened service providers already in the community.

What would be extremely helpful at this point would be for the Veterans Affairs Medical Center to successfully qualify as a homeless provider. This would make accessing of the VASH program possible in Albuquerque. As the situation presently exists, New Mexico is not even eligible for the VASH program, resulting in the loss of Affordable Housing for Homeless Veterans so desperately needed at this time, and so much a part of the solution to the problems heretofore described.

CONCLUSION

In conclusion, the Vietnam Veterans of America, Inc., Resource and Referral Center views the delivery of services of the Veterans Affairs Medical Center to be satisfactory in many regards. Additionally, there is significant evidence that every effort is being expended to improve that service, particularly with regard to some problems of long-standing.

We are aware that shrinking federal budgets require thorough examination of existing programs combined with implementation of new, more cost-effective programs. We applaud the effort but with some note of caution. Years ago Henry David Thoreau wrote that..."The mass of men lead lives of quiet desperation." The little known conclusion to the paragraph in which that was the opening sentence says..."But it is characteristic of wisdom not to do desperate things." We want our veteran clients not to have to do desperate things.

Mr. TOWNS. All right. Thank you. Let me thank both of you for your testimony and let me begin by saying to you, Mr. Cornell, thank you for that history lesson in terms of where the astronauts live and where the generals live. I think that was very informative.

Let me ask you about a marketing program. You expressed that. What do you have in mind when you say a marketing program?

Mr. CORNELL. A program that is either designed for television, public access television, or PBS, channel five is here locally, or a good talk show format, or a good, well-designed print outlet, which we have several, and having the thing thoroughly researched and balanced, particularly in the electronic media.

I firmly believe that you can get the local veterans service organizations to spin in with it. There needs to be a group pulled together to work with the media to explain the problems and go from there.

The biggest problem we have with the local media is that they are all young kids. They have never been in the military. A case in point, we had a solute to the Desert Storm people when they came home, which was absolutely gorgeous, and one of the TV people that was in charge of it was told to put a spin in for the Vietnam era veterans because of the slight they went through and I piped up and said, well, hey, if you are going to do that you have to do something for the Korean war veterans, too. And he said, "Oh Korea, that is ancient history." I said, "Thanks for making me feel so young." I went to some of the retired generals in the area and I said do you know what so-and-so said. Very quickly there were some changes in attitude.

We need to develop a comprehensive communicative vehicle that will talk to the veteran, to the person that is sitting at home and he can, say, oh, I didn't know that. I could get that at the VA? And then I know how to go about getting it and we do not have any of that. I think around the entire country there is probably very little of that being done. And you could certainly make a good pilot program out of it here and track record of the thing and if it works, turn it out to the rest of the areas.

But we have that Native American up in Navajo country and we have the other, the Indian Pueblos that need to be talked to in a particular way and we have the Hispanics as well as the Orientals and the others that are all veterans and they all say, just make it work. And it is not.

Mr. TOWNS. All right. I think you are right, I think it is an area we could sort of make a model based on what I am seeing here. This is an area we could learn about use it as a model.

Mr. CORNELL. Let me add here, Mr. Chairman, and it is a great pleasure I do get from the VA, my dad was a World War I veteran and he died in 1939 and I came up with his C file number and I said, hey, and one of the guys checked it in the computer and lo and behold in Michigan is my dad's C file. This is the main important documents, the veterans has. It is not his entire medical record. It is the creme de la creme of it. So I turned around and wrote the system a letter and I said under the Freedom of Information Act and as sole survivor, la, la, la, I want the file. I got it.

Do you know how big the Yellow Pages phone directory is in Washington, DC? Big enough to croak two horses at once. That is

what I got in the mail from the Archives and I looked at that thing and said if that is just the creme de la creme of my dad's records of a fellow that died in 1939 at the age of 44, good God, what does the whole file look like?

The system generates too much paperwork, too much busy, busy stuff. Clean that type of busy, business out, allocate that money to get the system to provide the medical services, and do the marketing that needs to get the customer count up, and Mr. Harwell and everybody else will be smiling.

Mr. TOWNS. Right. Thank you very much. I agree with you, paperwork is a real problem. We have had some programs that have almost failed and some that have failed because of the paperwork. You are right and we need to take a look at that at some point.

Mr. Shipley, I see the lights on, so I will raise this quickly with you. You mentioned social services provided by the medical center and I quote you, you say it is adequate and you said that twice.

Could you be specific about the areas which need improvement? Are there any areas you think that could be improved?

Mr. SHIPLEY. Are you referring to the written testimony I submitted?

Mr. TOWNS. Yes.

Mr. SHIPLEY. Yes; I think the first area I would touch on that I think needs improvement is, when it is known by VA medical staff that the veteran client is intentionally involved with the community-based agency which has significant records regarding treatment results of treatment and consequences of treatment, it would help to work cooperatively with those community-based agencies in establishing a plan of care that included everything, not only what was going to happen while the patient was in the VA hospital, but subsequent to the patient's release from the hospital.

We have had instances of homeless veterans treated for various medical conditions which required some intense followup after their discharge from the hospital and without the VA being at fault or necessarily anyone being at fault, after extensive medical treatment, they were literally discharged to the streets, homeless.

And when, for example, back surgery to correct an ongoing back problem has been done and the patient is discharged to sleep on the floor of a cave, the long-term results are going to be he will not get well and, in fact, in this particular instance this veteran client is going back in for second surgery. No services were provided once he left the hospital.

Those kinds of cases are instances where there needs to be active participation with a community-based agency that is providing services.

Mr. TOWNS. Right. My time has expired and I yield to Congressman Schiff.

Mr. SCHIFF. Thank you, Mr. Chairman. I just want to go back and emphasize that we have heard from both witnesses individual areas that they felt sorely needed improvement.

What I want to emphasize is that every organization has its day-to-day problems and challenges, and this would be true of our medical center here. It would be true of any medical center, true of any institution of government or private industry.

What I want to ask you is compared with other veterans' centers that you might be familiar with or compared with other kinds of services that are provided to veterans, I want to know if each of you can give me an overall rating, whatever you say it is, high or low, that you would rate our veterans medical center here on the whole.

Mr. Shipley, may I begin with you?

Mr. SHIPLEY. In my estimation, the VA medical center in Albuquerque is the best I have ever been affiliated with in any way whatever. And that includes about 1,500 VA hospitals located throughout the country.

Mr. SCHIFF. Mr. Cornell.

Mr. CORNELL. Ditto. It is fine, and I agree with what Mr. Shipley is saying. But, oh, it could be done a lot better.

Mr. SCHIFF. And I want to say, I am not trying to say that anything in any area cannot be improved. I just wanted to have this testimony in contrast to what I thought your full feeling was on that.

Mr. SHIPLEY. Yes, and before I submitted my testimony, I showed it to two of our veteran clients for feedback from them, and one of them said you are being entirely too critical of the VA. The second one said you are being entirely too friendly to the VA. So I figured I had it about right.

Also, there are some things going on there that I hope do not get overlooked that we consider to be excellent, and this institution of the primary care model, I think, is one of the most significant steps that could be taken. I think the hospital has been very thoughtful about how they went about it. I think the results are going to be a tremendous improvement not only in terms of the kinds and ranges of care that some of the veteran clients get, but I think that the VA staff will be a lot more satisfied with it as well as the patients. I think it is an excellent move.

Mr. SCHIFF. I thank both witnesses and yield back, Mr. Chairman.

Mr. TOWNS. Let me thank both of you, too, for your testimony. It has been very, very helpful. Thank you.

Mr. Fred Smalley, Department Senior Vice Commander, New Mexico Veterans of Foreign Wars; Mr. Allen K. Buttke, Past Department Commander of the American Legion of New Mexico; and Mr. Paul Stapleton, National Service Officers, Paralyzed Veterans of America. Would all of you please come forward.

Let me say to you what I have said to the other witnesses. All of you statements will be included in the record. That is every I, every T, every question mark, everything will go into the record, so if you would just summarize within 5 minutes, which will allow the panel the opportunity to raise questions with you after your testimony, I would certainly appreciate it.

So we will start with you, Mr. Stapleton.

STATEMENTS OF PAUL STAPLETON, NATIONAL SERVICE OFFICER, PARALYZED VETERANS OF AMERICA; ALLEN K. BUTTKE, PAST DEPARTMENT COMMANDER, THE AMERICAN LEGION OF NEW MEXICO; AND FRED SMALLEY, DEPARTMENT SENIOR VICE COMMANDER, NEW MEXICO VETERANS OF FOREIGN WARS

Mr. STAPLETON. Yes; Mr. Chairman, and Congressman Schiff, it is a pleasure for me to appear and provide testimony on behalf of the Paralyzed Veterans of America concerning quality of care at the Veterans' Hospital here in Albuquerque. And we extend a warm bienvenido to our Chairman here this afternoon.

Mr. TOWNS. Gracias.

Mr. STAPLETON. First, our primary concern is the spinal cord injury unit at the hospital. We are pleased that we have the SCI unit and we wish to thank Congress for appropriating funds for the unit. We also wish to thank our hospital director, Mr. Harwell, for his support in getting the unit as a part of the hospital.

As one of the more recent additions to the VA system of spinal cord injury medicine, Albuquerque SCI came on line in October 1989 as an authorized 30-bed facility. However, funding levels from inception have limited the number of operating beds to only 20, which the center currently operates.

Although the SCI center officially reports no waiting list, scheduled admissions for annual evaluations now regularly exceeds 1 year with some veterans scheduled 15 to 18 months in advance. Admissions for nonurgent treatment are limited by availability of beds.

Mr. Chairman, annual evaluations are an important part of preventive medicine in that they allow for early diagnosis and treatment of SCI and M.S. Health issues, thereby avoiding more serious and costly medical intervention. Admission to the SCI center for veterans in our catchment area outside Albuquerque and New Mexico from Denver to Oklahoma to El Paso and points beyond is sometimes deferred due to the lack of bed space. However, such deferral is not considered to be a waiting list.

We would also like to point out a policy of housing non-SCI ambulatory veterans in the SCI unit while awaiting admission to the VAMC.

We would like to make some commendations and recommendations.

No. 1, we do want to commend the hospital for its recent role in identifying substandard care at the veterans center in Truth or Consequences and the subsequent monitoring and on-site inspections by hospital teams.

To alleviate excessive waiting time for admission to the SCI center for treatment and annual evaluations, we recommend increased funding to allow staffing to open and operate 25 beds as soon as possible with funding to bring the operating beds to 30, 6 months later.

VA should continue to focus its health care delivery efforts with specialized services such as spinal cord injury medicine with a continued commitment to the maintenance and integrity of our 22 VA spinal cord injury centers. And in this regard we offer to the com-

mittee PVA's Health Care Department Strategy 2000 Phase II, which examines the future of the veterans health care system.

In summary, we are proud of our Albuquerque VA medical center and the Zia Spinal Cord Injury center. We trust that with your support, VA health care services to our veterans and to the community will continue to improve. And, again, we reiterate that our main concern is the underuse of our 30-bed SCI facility.

[The prepared statement of Mr. Stapleton follows:]

TESTIMONY
before
COMMITTEE ON GOVERNMENT OPERATIONS
on
October 8, 1994
by
Paul Stapleton, National Service Officer
Paralyzed Veterans of America

Mr. Chairman and distinguished Committee Members, it is a pleasure for me to appear and provide testimony on behalf of the Paralyzed Veterans of America concerning quality care at the Veterans Affairs Medical Center (VAMC) in Albuquerque.

First, our primary concern is the Spinal Cord Injury Unit at the VAMC. We are pleased that we have the SCI Unit and wish to thank Congress for appropriating funds for the unit. We also wish to thank the VAMC Director, Mr. R. Michael Harwell, for his support in getting the unit as a part of the VAMC. We must also thank our local Senators and Congressmen for their support. We have enjoyed having the SCI Unit available since October, 1989.

The Paralyzed Veterans of America wishes to express its gratitude to the Committee for extending an invitation to express the concerns of the veteran community, and more particularly, to express our concerns regarding the level of care of our catastrophically injured veterans including men and women.

As a Congressionally chartered veteran's service organization serving America's veterans, particularly spinal cord injury and disease (SCI/D) such as Multiple Sclerosis (MS), we welcome your presence and attention to the health care needs of our veterans living in and around New Mexico.

Veterans from the Great State of New Mexico are privileged to be served by a Federal Regional Medical Center with one of twenty-two (22) Department of Veterans Affairs (VA) Regional Spinal Cord Injury Centers (SCIC) serving not only New Mexico, but reaching veterans with catastrophic disabilities residing in several surrounding states.

Issues/Concerns

As one of the more recent additions to VA's system of Spinal Cord Injury Medicine, Albuquerque SCIC came on line in October, 1989, as previously mentioned, as an authorized thirty (30) bed facility. However, funding levels from inception have limited the number of operating beds to only twenty (20) which the center currently operates.

Although the SCI Center reports no waiting list, scheduled admissions for annual evaluations now regularly exceeds one year with some veterans scheduled 15-18 months in advance. Admissions for non-urgent treatment are limited by availability of beds.

Mr. Chairman, annual evaluations are an important part of preventive medicine in that they allow for early diagnosis and treatment of SCI and MS health issues thereby avoiding more serious and costly medical intervention. Admission to the SCI Center for veterans in our catchment area outside Albuquerque and New Mexico from Denver, to Oklahoma, to El Paso, and points beyond, is sometimes deferred due to the lack of bed space. However, such deferral is not considered to be a waiting list.

We would also like to point out a policy of housing non-SCI ambulatory veterans in the SCI Unit while awaiting admission to the VAMC. Since SCI veterans are sometimes deferred admission to SCI Unit due to non-availability of beds, we oppose such action. This practice has been discussed with VAMC staff.

This service organization is concerned with inadequate housekeeping and maintenance, especially of the grounds and courtyard. The environment within which the veteran is treated enhances speedy recovery.

In the past, veterans have been subjected to a practice known as "block scheduling" of clinic appointments whereby, several veterans were scheduled in clinic within a common time frame. Waiting times sometimes required the veteran to spend all day at the hospital to be seen in clinic. This practice is contrary to VA regulation and PVA would like to go on record as opposed to its use.

There has been some recent concern regarding waiting time to meet with the Wheelchair Committee for the issuance of prosthetic equipment. However, we have been advised that this is being looked into by our new Chief of Occupational Therapy with assurance that corrective action will be taken.

Because of our unique population distribution, strategic placement of outpatient clinics throughout the state allows rural veterans to receive VA medical care. While clinic staffing has been somewhat of a problem, this outreach program has been effective in areas such as Farmington and Gallup where our Native American Indian veterans are served. Not withstanding other clinical successes, we note that the Clinic in Raton has endured staffing problems from inception.

Commendations/Recommendations

We commend the hospital for its recent role in identifying substandard care at the Veterans Center in Truth or Consequences and the subsequent monitoring and on-site inspections by hospital teams.

We also commend Mr. Harwell and the staff for attempting to deal with rural clinic staffing problems by contracting with a private health maintenance organization to provide clinical medical services in outlying communities.

To alleviate excessive waiting time for admission to the SCI Center for treatment and annual evaluations we recommend increased funding to allow staffing to open and operate twenty five (25) beds as soon as possible with funding to bring the operating beds to thirty (30) six months later.

Paralyzed Veterans of America recognizes the necessity for VA to consider treatment of veteran's dependents and/or other appropriate non-veteran patients. We recognize that the unique capability of VA's specialized medical services may be shared to meet the needs of the non-veteran community. We must, however, remain on record that such sharing should always give our veterans first priority. Third party reimbursements, ie: medicare, DOD, private insurance, should remain with the VA facility providing the service.

VA should focus its health care delivery efforts with specialized services such as spinal cord injury medicine with a commitment to the maintenance and integrity of our twenty two (22) VA spinal cord injury centers.

In this regard, we offer to members of the committee PVA's Health Policy Department Strategy 2000, Phase II, which examines the future of the veteran's health care system.

Close

For any health care facility to survive and be competitive, it must provide the best possible patient service. This means recognizing patients immediately and not looking through them as if they did not exist. This means proper scheduling of appointments in clinics to ensure very little waiting time. This means putting the patient ahead of employees in all matters. This means providing the best medical treatment in an environmentally clean facility. All of this is necessary if VA is to survive within a framework of National Health, should such come about. All of this should happen even if National Health does not become a reality. Improvement in these areas is needed.

We are proud of our Albuquerque VA Medical Center and of the Zia Spinal Cord Injury Center. We trust that with your support VA health care services to our veterans and to the community will continue to improve.

Thank you for your attention.

Mr. TOWNS. Thank you very much, Mr. Stapleton, for your testimony.

Mr. Smalley.

Mr. SMALLEY. Mr. Chairman, Mr. Schiff, Congressman, on behalf of the 14,000 plus members of the Veterans of Foreign Wars in the State of New Mexico, I would like to thank the subcommittee for an opportunity to address the issues which we, the VFW feel of great concern involving the Veterans' Affairs Medical Center in Albuquerque.

The first issue is utilization of interns as surgeons. The VFW recognizes that interns are needed and are necessary as a functional process. Recently, the Department Chief of Staff of the Veterans of Foreign Wars was required to come in for a gallbladder removal due to cancer. This veteran became sicker and, by the third day after surgery, it was discovered the intern had nicked the large intestine. During another open surgery, the nicks were sewed up and the hospital requested he go home.

They did not know he lived 300 miles away. The veteran has been in their hospital for over 30 days letting the last surgery heal up.

The VFW recognizes there are third and fifth year medical people involved, but if an intern is allowed to do this type of surgery, how many other problems have arose from the training of interns? The veteran is not a playground for interns to gain experience nor to further their education. We, the Veterans of Foreign Wars, would like to expect medical care of that comparable to mankind in general.

We are currently awaiting the outcome of this veteran and his medical problem. We, the VFW, expect this veteran will be filing a tort claim after release.

Second issue is the cleanliness of the VA medical center. Complaints, not just from patients, but also nurses employed by the medical center have voiced a concern about the cleanliness of this facility. Syringes have been left laying around in rooms leaving the possibility of anyone being stuck. The bathrooms and the general appearance of the hospital is not up to standards required of the out-of-the-pocket hospital.

Issue three. In the last 2 years, the VFW office and other organizations at the VA medical center have been required to move three times. Each move takes the VFW responsibilities farther away. This is the care of veterans.

The VA currently has the VFW scheduled to move to an office that will not allow veterans the proper representative for any VA matters. All representatives are invited to come over to this area and you hopefully will realize veterans need the respect and proper representation allowed all veterans of the United States, not a hole to jump over, not a mountain to climb, but an honest house to go to for the ability to complain, file paperwork or simply talk to another VFW member.

Thank you.

Mr. TOWNS. All right, thank you, very much for your testimony.

Mr. Buttke.

Mr. BUTTKE. Mr. Chairman, Congressman Schiff, on my comments, many of these comments that I made in my statement may

seem a little negative in some aspects, but I observed this over the last 2 months and also during 13½ days of hospitalization on my last hospitalization there.

Since 1976, I have been hospitalized a number of times in the VA center here. It is one of the finest. Heretofore, I have always been a great advocate of the VA center. It gives excellent treatment for the most part and always has.

There are some things, like Congressman Schiff mentioned, you can find fault with anything. But in this last 2 months I think the deterioration over the past 2 years of this VA center has brought the attention of a lot of veterans to light. Mine was, I was hospitalized for side effects from a medication that was prescribed. Serious side effects.

Some of the other things that happened during that time were serious business because records were marked wrong. One of the medications that I had received was almost fatal and they put it on the record as could be very fatal if I took it, and somebody changed a jacket on the record and did not put it on there.

Things like this, these are oversights, but I think most of all the things that I am getting to in my report or in my testimony is the lack of funding for getting good doctors, good nurses and staff in the hospitals and getting good equipment that operates. I have seen a lot of equipment that was down.

I spent 7½ hours in the emergency clinic, from 5 o'clock until 12:30, after midnight, before I was admitted to the hospital. This is something I think was because of indecision of that doctor. The doctor was not an Air Force or DOD doctor. It was a VA doctor. Because I saw her upstairs later in the wards.

There was a lot of indecision made and there was some tests that were run and procedures that were run, I feel, not as a medical person, but just as the receiver of that is—just to give an example. One doctor ordered fluids taken out away from my lungs and my heart, which I had accumulated fluid from this Procainamide.

She had an intern do this procedure for the first time. It was done in my room and he missed. Well, it is not exactly a pleasant procedure. It was done 30 minutes later again and he missed again. And I said, there must be a better way. And the doctor got very mad at me, the resident that was ordering this, and said, yes, we can do it with ultrasound.

Well, they went down to the ultrasound lab the next morning, the young lady down there was excellent. She found the fluid, where it was, told the doctor if you will go here and only this much in, you will get this fluid. He did and got it. They took a great deal out of there.

It almost cost me my life by many indecisions. And I think that we need to look at the doctors and nurses. There were nurses making beds instead of doing their nursing duties. I think that is something that needs to be checked. We are very short of staff.

And, like I say, it is not administrative. Mike Harwell has done an excellent job with that hospital since he has been there, and some of the other directors and people that are in directors' positions, but I think it is funding. They are just not receiving the funding to be able to screen these people and take the time to screen them and to get them on board.

The other thing is that I think also a lot of them are not on board with handling veterans. They would be more conducive maybe in a hospital like Presbyterian, Anna Kaseman, or someplace like that, dealing with people of that type, civilians, more than veterans. I think they are not cognizant of the fact that the various—there are diseases like we do not even know from the Persian Gulf and we may go back there. What is going to happen? There is Somalia diseases we do not even know about, and probably Haiti has the same kind of thing.

So the VA is going to have to be tested to handle these and it is something we need to take a look at, and that is why my report was just a little bit on the negative side on that area. Thank you.

[The prepared statement of Mr. Buttke follows:]

STATEMENT OF ALLEN K. BUTTKE, PAST DEPARTMENT COMMANDER, OF THE AMERICAN LEGION, DEPARTMENT OF NEW MEXICO AND MEMBER OF THE AMERICAN LEGION, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION BEFORE THE SUBCOMMITTEE ON HUMAN RESOURCES AND INTERGOVERNMENTAL RELATIONS

October 8, 1994

Mr. Chairman & Members of the Subcommittee:

Please accept my sincere gratitude for allowing me to testify before this Subcommittee, it certainly is a privilege.

As a recent patient of the VAMC, Albuquerque and having the advantage of being able to discuss with other Veterans, one being an immediate Past Department Commander of The American Legion, concerning in and outpatient care, I have both good and bad developments at the Albuquerque, VAMC.

Approximately two years ago, the quality care and treatment at our VAMC was excellent, in mostly all areas, however, much has deteriorated to the point of grave concern to this veteran observer.

If I may, I would like to start my comments with the Outpatient Services and Clinics: Most of the Clinics are disastrously understaffed with very few Doctors for the amount of patients, scheduled, daily. The "normal" waiting time is four hours, give or take a few minutes. On outpatient services, I believe that the Administrative Personnel need to be a little more empathetic and understanding - a smile once in a while, would help! Personally, not long ago, I waited in the Emergency Room for over seven hours to be admitted - and I am a heart patient. Doesn't this sound a little scarey? And believe you me, many veterans are fighting for their right to receive decent treatment- the treatment that they were promised so many years ago.

Page Two
Many, many of the Wards are understaffed, and please understand that this is through no fault of Administration - these are all the cut-backs in funding. And, because of this under-staffing many patients are very neglected for long periods of time - and again, believe me - I have seen this personally (while an inpatient). Our Registered Nurses are being forced to make beds in addition to their other duties.

And, now, I am sad to have to report that there are a few Doctors and Nurses and medical staff at our VAMC in Albuquerque definitely not working for the best interests of the Veteran. The consensus of opinion is that the Staff is doing the veteran a big favor for the request of the slightest tasks. I have been hospitalized at the VAMC-Albuq.,
a number of times since 1976, and have always been given outstanding care but on my last admission, I was very surprized and disappointed in the lack of concern by some of the Staff.

It is my personal opinion that periodic inspections should be made of not only with the Staff but also individual patients.

Under funding has a lot to do with not hiring the best medical personnel - Doctors and Nurses and other Staff, as well as replacing old and broken down equipment. I witnessed a number of pieces of equipment not in use because of awaiting parts and repairs.

We have one of the finest VA facilities in the Country and it could be a model for others **BUT NOT THE WAY IT IS OPERATING AT THIS TIME.** A tour through the facility would show this. Talking to Staff who would not be in fear of losing their jobs and veteran inpatients would be a start.

In addition, I believe the Doctors and Nurses and other Staff working directly with veteran patients should be hired and trained on the differences that may have to be addressed between working with non-veterans and veterans. Many need to know that the veterans is **NOT A WELFARE OR CHARITY CASE, BUT THEY HAVE PAID FOR THIS CARE MANY TIMES OVER, ESPECIALLY IF THEY SERVED OVERSEAS IN COMBAT AREAS.**

Page Three
Our Veterans volunteered or were drafted with dignity and served as loyal Americans on our battlefields. They deserve the best health care that can be provided and should demand the dignity in its provision with the most skilled medical staff and best equipment available in our high tech society. To expect less would be a put down to every veteran that served, when needed.

In conclusion, I must add that many of the important programs in the Albuquerque VA Medical Center are well staffed and run very well, such as the VAVS - The VA Voluntary Services Unit, but others need to be observed more closely - to correct deficiencies.

This concludes my Statement, and I thank you for this opportunity to appear here today.

Mr. TOWNS. All right, thank you. Let me thank all of you for your testimony. I think it was Mr. Smalley who mentioned that interns were performing surgery. When they do that, are they not being supervised?

Mr. SMALLEY. Well, it would seem to me like they would be. It is pretty hard for me to understand that a certified surgeon would do such sloppy work.

Mr. TOWNS. What I was saying is I think what happens in a case like that is that the intern is there and then you have a senior person, a person that provides supervision while this person is in training. I would assume that is the case. I am hoping it is not a case where the intern just walks in and says this is my first time trying this and I never tried it before and I hope it comes out all right. I don't think it is a situation like that.

Mr. SMALLEY. I don't believe so. I am sure they have supervisors.

Mr. TOWNS. I wanted to make certain because we are making a record here and I wanted to make certain that it is clear.

The other thing you mentioned is that VFW centers have been required to move. Why do you have to move? I am just curious as to why you keep moving.

Mr. SMALLEY. This is what we do not understand. I believe my service officer is present. He could answer this question better than I could, my State service officer from the Veterans of Foreign Wars is present in the audience. Charlie?

Mr. TOWNS. Why do they have to keep moving?

Mr. NASSIF. I don't understand. First, we were in the main building number 41. We were asked to move out to building one, which was fine. We were close to the veterans. Then we moved out to the, at that trailer behind building 41, which is not too bad, but now for some reason we are being moved out toward district council, which is all the way across the hospital compound, completely away from the veterans. I don't know why.

Mr. TOWNS. I am just curious because I have a special interest, being a person that spent a lot of time in that area myself. I think being treated fairly is important. So I wanted to find out what was going on there.

Mr. SMALLEY. It is something, like he says, we do not understand either.

Mr. SCHIFF. Maybe your service officers, the gentleman who just spoke, could ask my office to get the response on that question.

Mr. SMALLEY. OK. You see, it is not only the VFW, all of the veterans organizations are being shuffled around.

Mr. TOWNS. Right. I think that veterans, when you go and you serve and you serve honorably and you come back, I think that we should never forget that. I just wanted to let you know I am one that will never forget it.

Mr. SMALLEY. I spent 21 years in there, I know.

Mr. TOWNS. Right. I will never forget it. Mr. Stapleton, you mentioned there is a waiting list, but there is not a waiting list. Yet somebody has to wait for year. How can they say it is not a waiting list if somebody has to wait for a year?

Mr. STAPLETON. Mr. Chairman, we are talking about two situations. One, annual evaluations and that, I mentioned in my report,

that they normally are scheduled 1 year in advance on an annual basis.

Mr. TOWNS. Right.

Mr. STAPLETON. Those are running in excess of a year now, as I mentioned in some cases, 15 to 18 months.

Now, in the second instance admission to the SCI unit for treatment is such that the hospital does not maintain a waiting list. If there is not a bed available, the veteran may be referred. If they are coming from out of our State, for example, Denver or El Paso, sometimes they are referred to another center and locally, in some cases, they are kept over in the main hospital until a bed is available in the spinal cord injury unit.

But officially, the hospital's position has been that there is no waiting list. However, we do know of veterans who have to go over to the main hospital under the care of nonspecialized staff who do not know, or who know very little, sometimes, about spinal cord injury until a bed is available in the spinal cord injury unit.

Mr. TOWNS. So, actually, in the sense that it is a waiting period.

Mr. STAPLETON. Yes sir, as we mentioned in the annual evaluation situation—Now, I come in for annual evaluations and for the last couple or 3 years I have looked at about a year waiting period to get scheduled for that evaluation which has been normal procedure.

Currently, of the 20 beds, the hospital has 3 of those dedicated to annual evaluations and there the veteran does not receive followup treatment. He simply goes through diagnostic procedures for early detection of conditions that need to be treated and then he is seen in clinic later for followup treatment.

And as I said, 3 of the 20 beds are reserved for those annual evaluations, and one is done on an outpatient basis. So the hospital right now is actually seeing 3 in patients a week, for annual evaluations, of the 20 beds that are available. So that, actually, only 17 beds are available for treatment of veterans when we have a 30-bed facility. It opened and authorized a 30-bed facility, but we do not and have never operated at that level.

Mr. TOWNS. At this time, I yield. My time has expired. I yield to Congressman Schiff.

Mr. SCHIFF. I somehow feel the need to add to the record my 25 years in the New Mexico Air National Guard and presently Air Force Reserve.

Mr. Stapleton, why do you believe that all of the beds are not open in that facility?

Mr. STAPLETON. Well, I am told, and we have met with staff, including Mr. Harwell, and our organization has met with Mr. Harwell about this, Congressman Schiff, and we have been assured by Mr. Harwell himself that whenever the numbers produce the need to open more beds, that he is committed to do that.

The numbers do not come out the way we need them to for the new beds to become available. But we do know, as I mentioned to you, we do know of veterans that are deferred admission to the unit and have to be kept elsewhere on occasion because there is not a bed available.

As I mentioned in my report also, that I did not take time to cover, is that nonemergency care of veterans very often is deferred

because of the available bed space. Decubitus ulcers, for example, which is one of the primary concerns of the spinal cord injury staff over there are sometimes deferred admittance because it is not an emergent enough situation to require hospitalization, and yet, decubitus ulcers, gone untreated, can deteriorate into a very critical situation very quickly.

Mr. SCHIFF. Mr. Smalley, Mr. Buttke, I am not sure that this is an explanation for what you have both described in terms of the quality of medical service and, in fact, I have to say in advance, my suggestion may turn out to be an injustice to some extent. But you have both described, in your case very directly, Mr. Buttke, about the person performing a procedure on you for the first time, and the implication, Mr. Smalley, in your testimony that somebody who did the surgery, though any surgery can go wrong, but the implication that the surgery was performed by somebody who had not done a great deal of surgery, those two testimonies together bring up the subject of the fact that the Veterans' Administration medical center here has an agreement with the University of New Mexico medical school that provides training for medical students and then onward for, I guess up the line in terms of residents at the VA medical center.

I have to tell you, in terms of the quality of service, I have never heard a complaint about that. I have heard—there may be some administrative matters, but I have never heard that the students and the interns and the residents were given responsibilities beyond what they are prepared to undertake, but that is sure what came through as a possibility in the testimony that the two of you have given.

I wonder, is that, in fact, where you are going or are these individual cases? In other words, are you suggesting these were the result of some decision of the UNM medical school in providing undertrained people for the level asked of them for doing procedures or, if not, how would you explain what you have described here?

Mr. BUTTKE. Well, sir, with two of the episodes, two of the procedures that were done, the first two were done with a resident present. The resident was from the UNM medical center. She was supervising this procedure. I do not know if she had ever done it before. She did not act like she had, but that is not for me to judge. I know the intern did as much as he could under the supervision.

However, on the third try, when we went to ultrasound, there was no resident available. There was the intern that had done the first two procedures and the girl running the ultrasound, the specialist there, which did an excellent job. She was proficient and very nice and did her job very well because she got him right there.

Mr. SCHIFF. Let me ask more generally, I will come back to you, Mr. Smalley, and, again, I may be misreading this totally, so let me ask it as a general matter. Have your memberships made any kind of complaint about the fact that there is medical training going on in the facility? Do they feel that in any way has compromised the level of service that they have gotten?

I want to stress again, to be fair here, I have never heard such a complaint, but in listening to your testimony, I wonder if there is something there.

Mr. BUTTKE. Sometimes, sir, there has been—some of our members—and of course, we get it from mostly members. I know Mr. D'Arco with the Veterans Service Commission, he gets it from a lot of people, but not—they do not normally complain to the Veterans Service Commission. They complain mostly to the VFW or the American Legion, in our case, and I get a good many of them because I am on the VNR Commission nationally for the American Legion.

But in my stay there, when I was mobile enough, I did get a lot of feed in from some of the staff and also from seeing things that are done and witnessing, for instance, some of the equipment downs that are sitting there waiting for work to be done.

And, again, I say that is probably funding. I don't think that is administrative. But those kind of complaints we get for the time element for the clinics, for instance, those I got from—I have never had to wait very long, except the one time in emergency, that seven-and-a-half hours. But I have waited two and 3 hours, but never over four. And some of the complaints that we get are well over four because they have two doctors in the clinic, and quite a few more patients scheduled for that day than that doctor or those two doctors could handle. And they sit there for quite a number of hours and before they are seen.

I think sometimes this could be of a kind of critical nature because some of these veterans that go in, especially the older ones, are not too well to start with. And they go in on these appointments and they may need immediate medical attention, but nobody seems to bother with them too much in the waiting room.

Mr. SCHIFF. Mr. Smalley, let me turn to you now, sir. I am interested in knowing whether in any way any of the quality difficulties that you have suggested may exist, is that related in any way to the teaching nature of the hospital?

Mr. SMALLEY. No, Congressman, I believe—well, I think probably it is mostly isolated things, all of them, all these complaints, sir.

My own personal feeling, I have been going to the Veterans' Hospital over here for the last 6 years and I have had treatment for everything from a broken arm up to a heart bypass, quadruple bypass I had and I have gotten nothing but excellent care and excellent treatment. That is my own personal experience.

I had one instance where they had to take cancer off my ears. One doctor did this ear and did an excellent job. This one you can see is full of holes. I know the one that did this, but between the two of them he had got transferred before I could get this one operated on. So that is the reason—I don't know who the doctor was that did this one. I am very unhappy with it. They have said they will fix it but I don't want to fool with my ears no more. I am getting too old for that.

As far as the care in the medical center, like I say, on my own personal things it is excellent.

Mr. SCHIFF. Well, I thank you. And as I said, I went off on a line here I have never heard before and was pleased it is not what you are saying in terms of your testimony. I yield back, Mr. Chairman.

Mr. TOWNS. Right, thank you very, very much. Mr. Harwell mentioned block scheduling and he explained it to me so that I now understand it. I guess, Mr. Buttke, let me ask you this question.

What would you believe is an acceptable amount of time for a person to wait if he has an appointment.

Mr. BUTTKE. An appointment.

Mr. TOWNS. Yes; if he has an appointment.

Mr. BUTTKE. Well, sir, depending, again, on the amount of staff that is available, probably from one to maybe two or perhaps 3 hours. I have seen this. I have done it myself. It is not overburdensome because if the doctors are going to spend enough time with the patient—some of the complaints the doctors say I just do not have enough time with this patient or with you to be able to do some of the things I would like to do so they order the tests.

I think that would be a pretty good round figure. Over 3 hours I think is exorbitant and anything under three I think is fair because some of these doctors, I think, are very overworked.

Mr. TOWNS. Mr. Stapleton would you like to add something to that?

Mr. STAPLETON. Thank you, Mr. Chairman. I believe that the goal of the hospital, as put forth by Mr. Harwell, is 30 minutes. I don't know if that is a realistic goal. I agree with Mr. Buttke over here that normally, for a clinic appointment, I would expect to maybe wait an hour and not be alarmed at all. But if the hospital schedules 20 patients to come into clinic to be seen between 9 o'clock and 12, for example, that is block scheduling. They will bring in 20 patients to be seen between 9 and 12. And this is all set up well in advance.

And then let's say for some reason one of the doctors does not make it or two of them do not make it, so instead of having six or seven scheduled appointments sitting out there then you have got 20 people that do not know when they are going to be seen or maybe have to wait until the end of the morning, until 11:30 or close to 12 before they are seen in the clinic and they will be out there for 3 hours. There are some reports veterans had to go over the lunch hour and then wait there essentially all day and I myself am one of those veterans who have had on occasion, had to wait out there all day to be seen in the clinic.

Paralyzed Veterans of America was one of those that voiced the opinion of being on record against block scheduling and we do not think it should be practiced here. And, to my knowledge, the hospital is not currently engaged in it and we commend the staff for listening to the veterans and we hope that will continue to be the case.

Mr. TOWNS. OK. Well, let me thank you again for your testimony, all three of you. I think that we have learned a lot from what you had to say and thanks again for coming and sharing. Thank you, Mr. Stapleton, Mr. Smalley, and thank you very much, Mr. Buttke.

Mr. SMALLEY. Thank you.

Mr. BUTTKE. Thank you.

Mr. TOWNS. At this time I yield to Congressman Schiff for any kind of closing statement he may have at this time.

Mr. SCHIFF. Well, just to express my appreciation for everyone's testimony. I think that we heard some very frank testimony. I think that the veterans, as I indicated to you, I thought it would, Mr. Chairman. I think the veterans' medical center here got very

high marks from the people it serves, and I think to the extent that problem areas exist, I am very appreciative that Mr. Harwell and the staff stayed and listened to the entire testimony. I am sure they were making notes on the subject and I have confidence that they will address these different issues.

The main thing, though, is that I am very pleased that the experiment of joining together the Air Force and the medical center seems to be working well. As Mr. D'Arco mentioned, a lot of people were very skeptical about that. I tell you, I was one also. But, on the whole, and acknowledging there are problems there, too, as everywhere else, on the whole, I think it is an experiment that can be looked on as a model for these agencies.

I yield back, Mr. Chairman. Thank you.

Mr. TOWNS. All right. Let me thank you, too, for suggesting that the subcommittee come, because I have learned a lot. From your written statements, we will be able to learn even more. And, we will share all this information with other Members of Congress.

As I listened to the comments made in terms of scheduling, I know that it is always going to be a problem. If you schedule 20 and, of course, only 10 show up, that is a problem. Of course, if you schedule 20 and one doctor is tied up somewhere else, that is a problem. So we are always going to have some problems. I think the key is you recognize where the problems are to continue to work on them.

I must say that I have been around the Congress for many, many years now, and I have gone out to many, many field hearings, especially in the area of health care. I would have to say that based on the information that we have received here, I am impressed with what is going on. I think there is something that we can learn here and I think we can make this a model for other areas as well.

So I would like to say to you, Congressman Schiff that I think that we really have something going here in Albuquerque and we look forward to working with you in terms of the areas that need to be strengthened. But more than that, it is important to try to get this information out to others around the country as to what you are doing here.

So thank you again for suggesting it and thank all the witnesses for coming, and here, again, I thank you Mr., Harwell, for staying as well, because I think that is important that when you get feedback, it demonstrates the fact that you are committed to trying to correct whatever problems there might be. But I also want to applaud you for the kinds of things you are doing, because it seems to me you are moving in the right direction.

At this time the subcommittee on Human Resources and Intergovernmental Operations hearing is now adjourned.

[Whereupon, at 3:40 p.m., the subcommittee was adjourned.]

[Additional information submitted for the hearing record follows:]

Joe Richard Gonzales
809 Marshall Lane
Socorro, N.M. 87801

President Bill Clinton
1600 Pennsylvania Ave.
Washington, D.C. 20500

August 29, 1994

Mr. President:

Let me introduce myself. I am Joe Richard Gonzales from a small city in the state of New Mexico. I am a veteran who served over 21 years in the United States Navy. I am currently the Commander for the Disabled American Veterans chapter 24 Socorro, NM. I am also the Second Vice Commander for Post 4383 of the Veterans of Foreign Wars Socorro, NM. As a veteran and officer of these organizations, I am compelled to write this letter to you and send copies to all listed as "copy to".

I was admitted to the Veterans Administration Medical Center (V.A.M.C.) Albuquerque NM, on August 8, 1994 for surgery on my lower lumbar spine. During my stay I was surprised, thoroughly disgusted, angry, and frustrated at the events that took place on the ward.

I am having difficulty deciding where to start. I hope you will take the time to read all of what I have written. I checked into ward 4A room 104 bed 4 on or about 9:00am 8 August. I was in a room with three other veterans. I stayed on the ward all day awaiting new instructions. Dr. Malone and his assistant Dr. Newcomer came around about 7pm to explain what would be taking place on Tuesday 9 August . I asked Dr. Malone if my mother in-law could be allowed to be at my bed side during my recovery. Ms. Sandoval is a B.S.,R.N.. He said she would be able to help but not in any official capacity. I then pointed out that no blood had been taken and I had not been seen by the anesthetist. They seemed surprised that nothing had been done. That night, I had blood drawn, an EKG done and a chest x-ray. The anesthetist also showed up. The following day I was taken to pre-op and was astonished to hear that I had been penciled in that morning. The pre-op people did not know I was coming in. The surgery was scheduled a week before.

After surgery I remember Dr. Malone telling me that every thing went OK except that the removal of a fragment that had attached itself to the spinal cord caused a small tear in the dura. The tear was too small to place a suture. This required me to remain on my back for a period of 48 hrs. During this time I developed a blockage which required me to be moved to the X-ray dept for x-rays of my stomach. Shortly after returning to my room, an NG tube was inserted into my nose and down to my stomach. The NG tube was inserted

wall that the attending nurse we had for the day was outside speaking to someone. I then pushed my call button and I noticed that she turned and looked at the light over the door. She then returned to the conversation. After a minute she turned and checked to see if I was watching her through the mirror. When she turned around, I signaled through the mirror at her to come over. She broke the conversation and came in the room, asking me if she could help. I stated that I did not need the help, Mr. Grubb did and that he had been waiting for a long time. I knew that the lights outside were on because she reset both call buttons at that time.

At 1:25pm another nurse walked in and asked me if I was going to my Occupational Therapy appointment at 1:30 pm. I looked at my attending nurse and said I was never told of the appointment. The other nurse stated that it had been written on the board for sometime. I then requested a wheelchair so my wife could take me down to my appointment. I was late but was still seen.
I finally checked - out at 4:40pm. August 15, 1994

This describes my stay at the V.A.M.C. Albuquerque.

Now I wish to comment on some of the other observations I have that are very troubling to me.
I asked Mr. Castro and Mr. Grubb if they would give me permission to use their names in the letter I would be sending out. They both agreed and encouraged me to pursue this matter.
On Saturday August 13 Mr. Castro, who was in bed 1, fell while trying to get in to his bed after being out in his wheelchair. He had an accident then where his bowels let loose on the floor and in his bed. The nurses came in and started to attend him. He started to vomit also and was having other medical problems. The staff cleaned him and his area up. A dirty mop and mop bucket were left in the room. On Sunday afternoon before I had gotten my lunch, Mr. Castro was sitting in his wheelchair and as I was coming out of the bathroom I heard him attempting to vomit. I ask him if he was all right he turned and gave me a look with which I knew he was very ill. I turned to my wife and told her to run to the nursing station and get help NOW. Staff got there in good time and started helping Mr. Castro. We told them that he had a fall the evening before. Mr. Castro had another accident and his bowels let loose again. The staff assisted him to the bathroom to clean him up. Shortly after that the toilet backed up. The mop and bucket that had been used the day before got reemployed to clean the floor again. The smell was so bad that we moved to the lounge next door. When all was said and done, the mop and bucket were still left in the room. I checked to see if at least the water had been changed and it had not. I am sure glad that I don't have any open wounds on my feet.

The other thing I observed is that not all the staff pickup after themselves. Not just in my room, but others also, because when I walked around the ward , I could see in the rooms that bandage wrappers, bandages and other items would be left on the floor or on tables around the patients beds.

On Monday after I had the talk with Dr. Newcomer, I noticed that the person who cleans the room cleaned the floor around the beds a lot better. He also cleaned the bile around my bed. Shortly after that, a

Wednesday afternoon . The tube leaked all over my bedding and on the floor next to my bed. Members of my family kept working to keep me clean and with fresh bedding. Bile was removed for 24-28 hrs. The removal of the NG tube was completed Friday afternoon. The doctor requested I be fed clear liquids for 24hrs, and if my bowel system returned to normal I would be allowed to return to a regular diet. (FOOD) My system started to work normally early Saturday morning. I asked that I be placed on regular diet as the doctor ordered. I was anxiously awaiting a good lunch and none arrived. I got liquids again. The nurses stated that they did not have written orders allowing me a regular diet. I told them to call one of the doctors and get permission for the meal. All day Saturday it was the same statement " The doctor on call will not answer his beeper." Sunday morning came with the same story all over again. I had been there for 5 1/2 days without solid food. It was not until 2:30 pm that a sandwich arrived. One of the doctors had finally been contacted.

Monday morning August 15 about 7:15 Dr. Newcomer checked on me and said I would be going home that day, as soon as I could be seen by occupational therapy. They would evaluate and determine what prosthetic items would be needed at home for my safety. At this time I asked Dr. Newcomer if he had a few minutes because I had several complaints. He said he would be willing to hear what I had to say. I started with: Why didn't anyone answer the pager Saturday or early Sunday? He stated that the page the nurses were calling was turned off because that doctor was not the one on duty. Why is it that doctors statements concerning treatment to the patients seem to not get written for the nursing staff? I asked why the floors didn't get cleaned around the patients beds. I asked him to walk around my bed to where the NG tube was hooked up and see that the bile that leaked all over the floor from Wednesday and Thursday had not been cleaned up as of yet.. I also asked why does it take so long for help to arrive when a patient uses the call button. Why aren't the beds changed on a regular basis? Why personal hygiene is not required of all patients? Why is it that when a doctor was in treating a patient in bed 2 there was no nurse assisting him? The doctor had to place some sutures on the man's foot. My wife was asked to help the doctor. She got something he needed out of his pocket, she also had to turn on the light so he could see the area better. She asked him if nurses ever help them do things like that, without hesitation he stated "No, they don't."

After Dr. Newcomer left, I waited for the therapy people to show up or find out when the appointment would be. During this time three events happened that insured me to take up the pen. I was fed up with what had happened during my stay and the flagrant disregard to duty. During the morning hours while I was waiting I walked up to the windows and looked outside. As I turned to speak to Mr. Grubb, who was in bed 3, I noticed something different about a windowsill. I walked over and noticed a syringe needle sitting on end on the windowsill. I pointed it out to my wife and Mr. Grubb. The nurse who was attending us walked in and I pointed out the needle on the windowsill. She seemed surprised. She then carefully picked it up and disposed of it in the needle container. I wonder how long it had been there and if it had AIDS. Later that day I laid down for a few minutes. I noticed that Mr. Grubb was sitting up and I asked if anything was wrong. He said that he has been waiting for someone to answer the call button because he needed to go to the bathroom. (Mr. Grubb is unable to get out of bed by himself or he runs the risk of falling.) I was able to see through the mirror on the

person came in and proceeded to clean and remake bed 2, what seemed strange is that he wiped trash out of the bed onto the freshly cleaned floor and just left it there.

This letter appears to be all negative, but there are good things I encountered during my stay that I and my family GREATLY APPRECIATE AND ARE FOREVER GRATEFUL.

The Doctors that worked on me have greatly renewed my faith in the medical ability of the V/A system. I personally wish to extend a gracious thank you to Dr. David Malone, Dr. Baldwin, Dr. Newcomer, and Dr. Caruso for their unquestionable ability to help veterans like myself have a better quality life, life without pain.

I wish to acknowledge and recognize the glistening diamonds that exist in the nursing staff. Their dedication to duty and their humane treatment of patients exceeds the standard of excellence. More are needed that unselfishly give of themselves to help veterans recover from their ailments with dignity and a sense of worth. Without these glimmering diamonds, you would have more veterans requiring longer stays. These few, in my opinion, make the rocks around them shine as a whole. Even with these few, I truly feel that family members should be encouraged to help take care of their own veteran during their stay on this ward. With great pleasure and uncompromising gratitude, not just from me but from my entire family, I wish to thank Ms. Grace Jojola, Ms. Sandra Soprano, Mr. Kevin Capeless, Ms. J.C. Green, Ms. Carrie Randell, and Ms. Cinthia McCorvey. I also wish to acknowledge the X-ray dept for their courteous and expeditious service to my case. Also, I wish to acknowledge the staff of the Occupational Therapy Dept. for their professional approach in assisting me in my needs and my well being.

P.A. Jerry Montoya (Primary Care Provider Group A) is the individual that has been working with me from the onset. He continually pushed for further study and testing until the final diagnosis was made and surgery was required. Without him taking personal interest, I would probably be bed ridden. I do believe his professional and unyielding dedication to assist veterans is a quality and quantity that needs to be recognized and supported by all. Thank you, Jerry.

Mr. President, I have said a lot but I feel that this type of treatment of Veterans is shameful and discredits the honor of serving this nation. When war or the threat of war appears on the horizon, our military are made ready and strong commitments are boasted by the leaders of this nation to support the future well-being of all who serve. Once the guns of war or the threat of war diminish the leadership and the public begin to forget about the strong commitments that were made to those brave men and women who stood so valiantly in harm's way.

We, the veterans, who stood valiantly and saw with our own eyes and suffered in our own bodies the ugly truths of war deserve to be treated with dignity as individuals, with compassion and respect. Illness in itself is an indignity that has to be borne, but it should not be compounded by staff who treat us worse than charity patients.

The V.A.M.C. Albuquerque is a training facility, and as such, shouldn't it be exemplary in preparing the doctors of the future? Or should we as a people accept mediocrity or worse? One of your HOT programs wants to place the nation under such a system. I prefer to fix what we know is broken instead of trying to reinvent the wheel again, with more bureaucracy.

I would like you to ask Mr. and Mrs. Castro why he had to lose his big toe. As I write, he is still in the hospital. When I checked out, I felt like I was abandoning a shipmate. I should not have to feel that way. He served in the Korean War and came home with all his toes and now he is missing one.

I know that I have taken a bit of your time but I would appreciate a written response as soon as possible.

Respectfully,

Joe Richard Gonzales
U.S.N. Retired

cc. Senator Dole
Secretary-Dept. Veterans Affairs
Senator Domenici
Senator Bingaman
Senator Hutchinson
Congressman Schiff
Congressman Richardson
Congressman Skeen
National Commander D.A.V
National Commander V.F.W.
Governor King-- State of New Mexico
Dept. of Veterans Affairs Regional Office
State Commander D.A.V
State Commander V.F.W.
The American Legion Dept. of New Mexico
R. Michael Hardwell Director V.A.M.C. Albq.
Micheal Brady D.A.V. National Service Officer
Commander V.F.W. Post 4383 Socorro, NM
file

October 8, 1994

To Whom It May Concern:

My name is Gloria Sandoval. I am 60 years old and currently employed by Albuquerque Public Schools as a school nurse. I have held this position for 18 years. Concurrently I worked as a staff nurse at St. Joseph's Hospital Downtown on the orthopaedic floor, a position I held for 19 years. I received my Bachelor's Degree in Nursing from the University of New Mexico in 1994.

I am writing this letter to express my dismay and concern with the nursing care (or lack thereof) that I observed at the Albuquerque Veterans Administration Medical Center during the week of August 9 through August 15, 1994.

My son-in-law had back surgery (removal of a ruptured disc) the morning of August 9. He had obtained permission for me to be allowed to help with his care; however I was not employed in an official capacity and I fully understood that. During the late afternoon and early evening he began to experience abdominal discomfort, nausea and vomiting. Right after his surgery I noted that while his vital signs (temperature, pulse, respiration rate and blood pressure) were taken, no nurse ever did a complete assessment on him; part of this assessment would include listening to lung sounds, bowel sounds, checking pedal pulses and checking the condition of his dressings. I listened for bowel sounds and not hearing any I asked 2 or 3 times during the evening for one of the nurses to come check them and call the doctor. No one ever came and since I was not "official" I could not call him myself. By the next morning when his doctor made rounds his abdomen was very distended and hard and he was now vomiting bile. There was some concern that he could have an

obstruction and he was taken to X-Ray. After returning to the room a naso-gastric tube was inserted to facilitate drainage until such time as his bowel started working again. The tube leaked on the floor and the material stayed on the floor until the following Monday (almost 5 days.

I bathed my son-in-law daily and changed his bed as often as it was necessary. There were three other patients in the room and none of them was ever even offered a pan of water for a sponge bath, nor were their beds changed on a daily basis. When one of the other patients was bathed it was because he had an accident and was soiled.

When Joe (my son-in-law) was able to get up and walk, he wanted to go to the bathroom. Before I would let him use it I put gloves on, got a cloth and soap and scrubbed the commode and the Hi-John because both were filthy.

When one of the other patients had an accident and had a bowel movement on the floor, the nurses swabbed it up with a mop and bucket. The mop and bucket then remained in the room and were reused when the same thing happened again. The Mop + bucket were there almost 2 days and I finally moved them out of the room into the hall. I understand that some of my complaints have to do with housekeeping but I feel that if the nurses were on top of things they could have caught them and prevented them. I did not see any nurses make rounds with the doctors and as a result there was a lack of communication when orders were concerned. Lights were not answered on a timely basis and, as much as I hated to do it, I would go looking for the nurses when Joe needed pain medication.

I feel sorry for some of the older veterans who do not have anyone to be an advocate for them. They are treated

like second class citizens. Whatever medical care they are receiving is not "free". They have more than paid for what they are getting.

It is difficult to try to remember and cover everything in a letter. I did finally get an appointment to speak with the director, Mr. Harwell on September 20, 1994. He was very upset over the letter that Joe had written. I tried to tell him that he wrote it from his perspective and I was trying to speak to him from my perspective as a nurse. I did not get the impression that he wanted to hear what I had to say. I felt he agreed to see me because I refused to speak to his subordinates. He didn't come right out and call me a liar but he came close. He said he was going to call for an investigation and would subpoena my statement if necessary. I told him I would be happy to give my statement to anyone. He also never really let me finish my statements.

I have an appointment with one Ms Millard on Wednesday October 12, 1994 at 4:00 p.m. She said our session would be recorded. I will be more than happy to tell her what I have told you and since it will be verbal I can go more into detail.

If I can be of further service please call me at home 294-0092 or at work 764-2006 or 764-2021.

Thank you very much.

Sincerely,

Gloria Sandoval, RN

American Federation of Government Employees

Local 2063
2100 Ridgecrest Drive SE
Albuquerque, New Mexico 87108

October 11, 1994

OCT 2 1 1994

Congressman Steve Schiff
625 Silver Avenue, SE
Albuquerque, NM 87106

Dear Mr. Schiff:

This document is a statement in response to your request at the House Government Operations Subcommittee hearing held here in Albuquerque on October 8, 1994.

I am the president of the American Federation of Government Employees local 2063 affiliated with AFL/CIO. I represent one thousand employees here at the Veterans Administration Medical Center, Albuquerque, New Mexico. Over half of these employee are veterans.

At your request, I am offering, in testimony for the record, the observations made by labor.

First, let me say I felt that the testimony offered by Mr. R. Michael Harwell was far too modest. For the past year, Mr. Harwell has opened more specialty clinic areas, providing a wide variety of treatments with less waiting time, yet offering the same quality of care or better than before. He has converted the system to a primary care facility and expedited enrollment time. What used to be a long, tiresome wait for our veterans is now, for the most part, a minimal wait.

Our women's clinic is a new and growing service. As with all new services, problems do arise, but these are being worked out one step at a time.

It is Mr. Harwell's stated intention to make every clinic as productive and efficient as possible. With the introduction of health care reform, both national and state, Mr. Harwell has already made this hospital significantly more competitive with other private and state facilities.

There are also plans for more community-based clinics throughout the state. These clinics will offer a wide variety of services and treatments to our veterans in the more remote areas of this state.

It is also Mr. Harwell's intention to provide expedient, quality care to every veteran in this district, and with the

implementation of his new and innovative ideas, it seems to be working. More and more veterans are coming for the services of the Medical Center, whether it be at the hospital here in Albuquerque or at one of the more remote clinics that we have. He wants to please all our customers -- our veterans, and they are foremost on his agenda.

Customer service is the essence of our survival, especially when national health programs are initiated. We need to be competitive, as well as providing veterans and/or their families with the best care possible. Mr. Harwell has initiated this, and it seems to be working.

I also listened to the testimony of the Special Interest Groups present at this meeting. It appeared to me that that is just what it was, "Special Interest Groups seeking special attention." Certainly, Mr. Harwell is sympathetic to the individual needs of each group, however, lines of communication need to be set up with each interest group, and their needs need to be discussed. Again, Mr. Harwell has conveyed his concerns about special interest groups. For example, no spinal cord injury patient has ever gone without admittance when needed. He may have been sent elsewhere, but admittance was guaranteed.

Another example of his concern is the homeless veteran. If staff are aware that a veteran is homeless, he has instructed his staff to notify Social Services and find placement for these veterans. At NO time is a veteran to be discharged to the street!

Decisions regarding special interest groups might be described as the needs of many outweighing the needs of the few with exceptional needs as highest priority.

Change frightens everyone and I'm sure this is the motivating factor of all the groups present. Only an open mind and open communications can alleviate their fears.

The one theme that all of the specialty groups agreed upon was "GREAT CARE," and "the best hospital I've seen in my travels." This says a lot about our hospital and the effect of Mr. Harwell's planning. A.F.G.E. Local 2063 is not only aware of these changes, but we feel that we are working together and we are proud to be a part of this new concept.

Mr. Harwell is trying to complete an almost impossible task with impossible odds. One of the odds he faces is the lack of personnel. To complete his job, he needs more full time employees, not less.

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I disagree with the personnel cuts in the Veteran Hospitals as demanded by Washington. We are working at minimum staffing now. Everyone in the labor force is putting forth 100 percent plus. Our labor force is tired, yet, as a sense of pride in our hospital and out of respect for our director, they continue their outstanding work. We need employees. When more employees are available you will then be able to visualize the optimum in a health care facility.

Here in New Mexico, the system is working. Veterans and civilians are taking care of veterans. Labor and Management are working as a team to provide the best care possible to all who seek health care. We both are ready to compete with outside facilities. We are proud of our facility and our outlying clinics. Union and management working together, here in New Mexico, hope to set an example for the rest of the nation.

Sincerely,

Frederick M. Groeger

Frederick M. Groeger
President, AFGE 2063

cc: Senator Pete V. Dominici
Senator Jeff Bingaman
Director, R. Michael Harwell

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